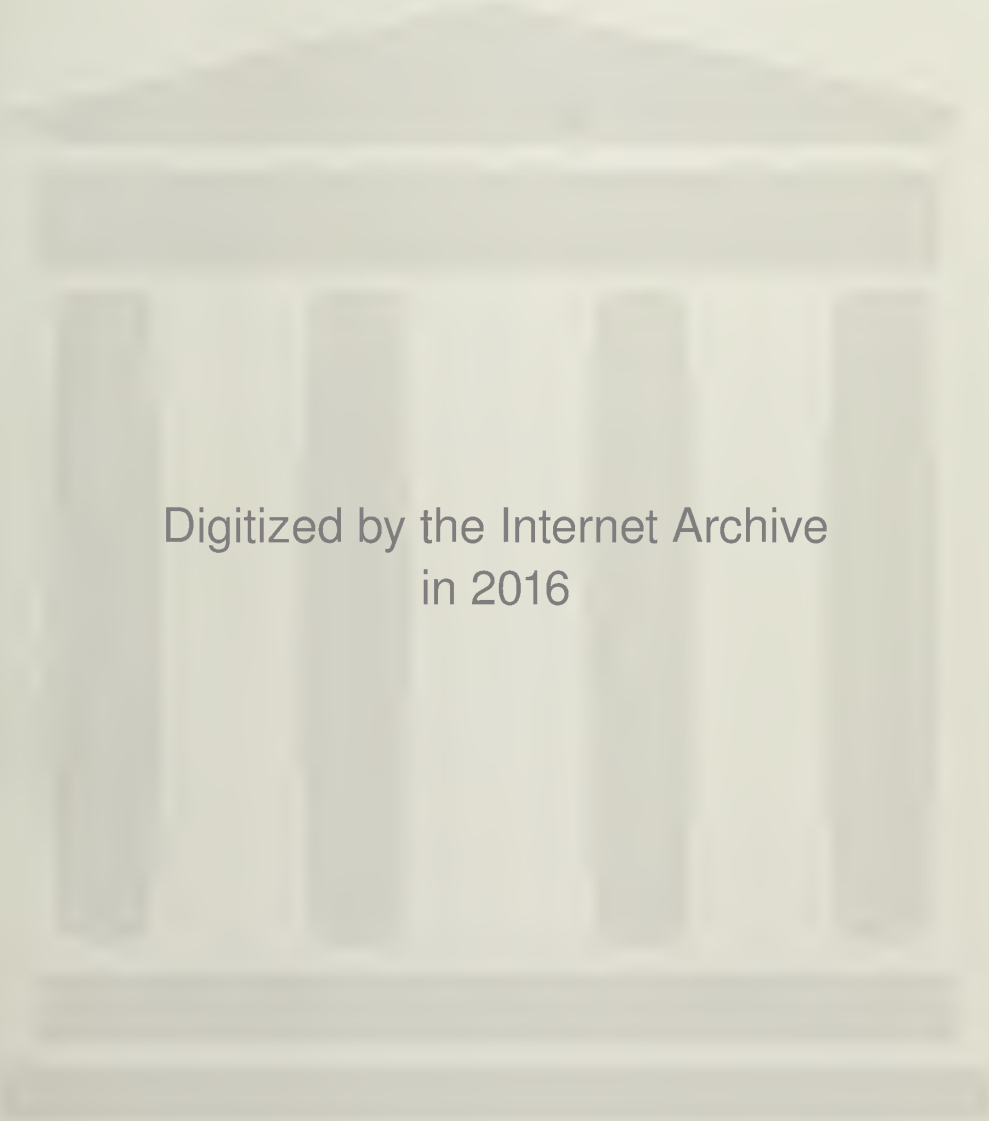


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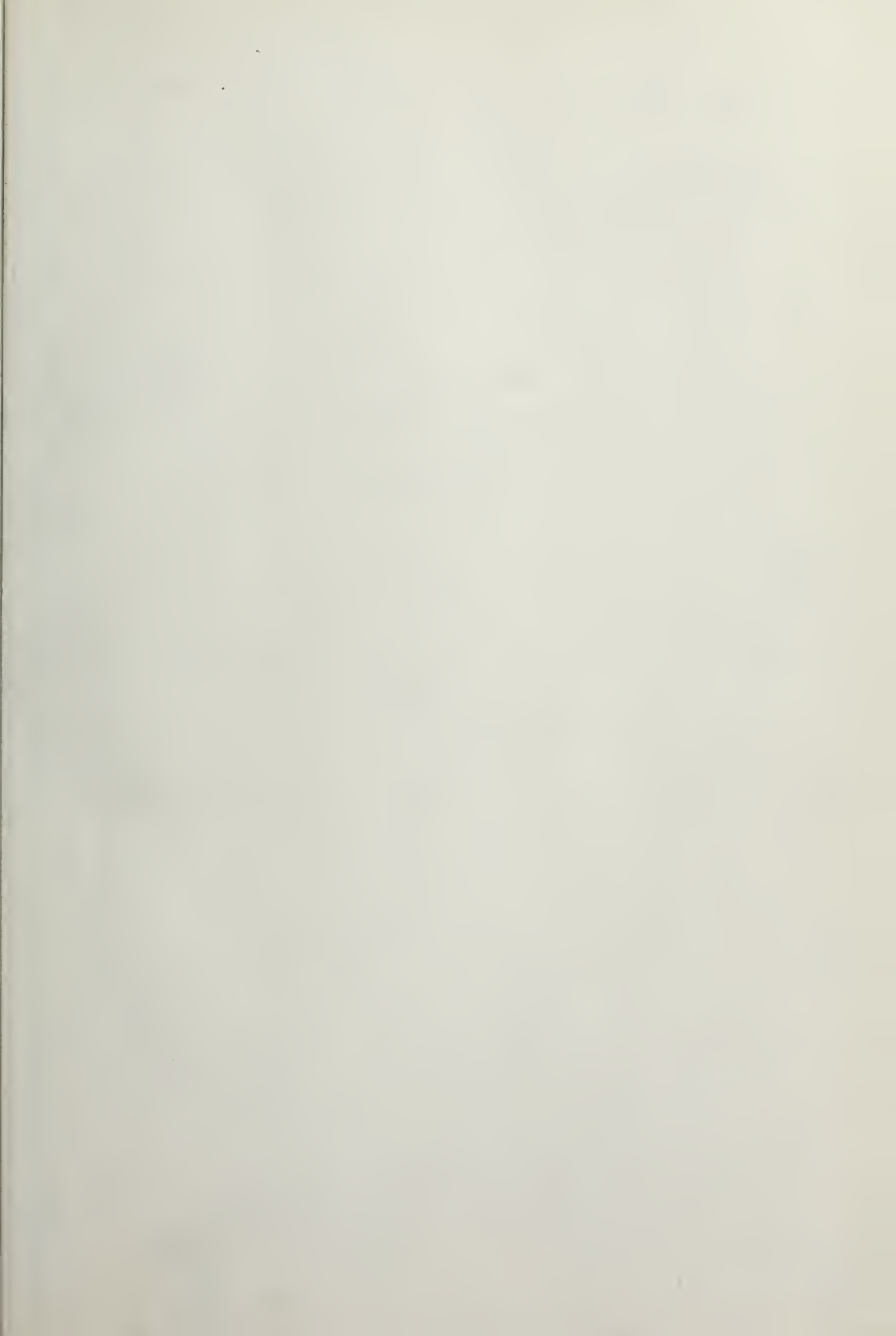


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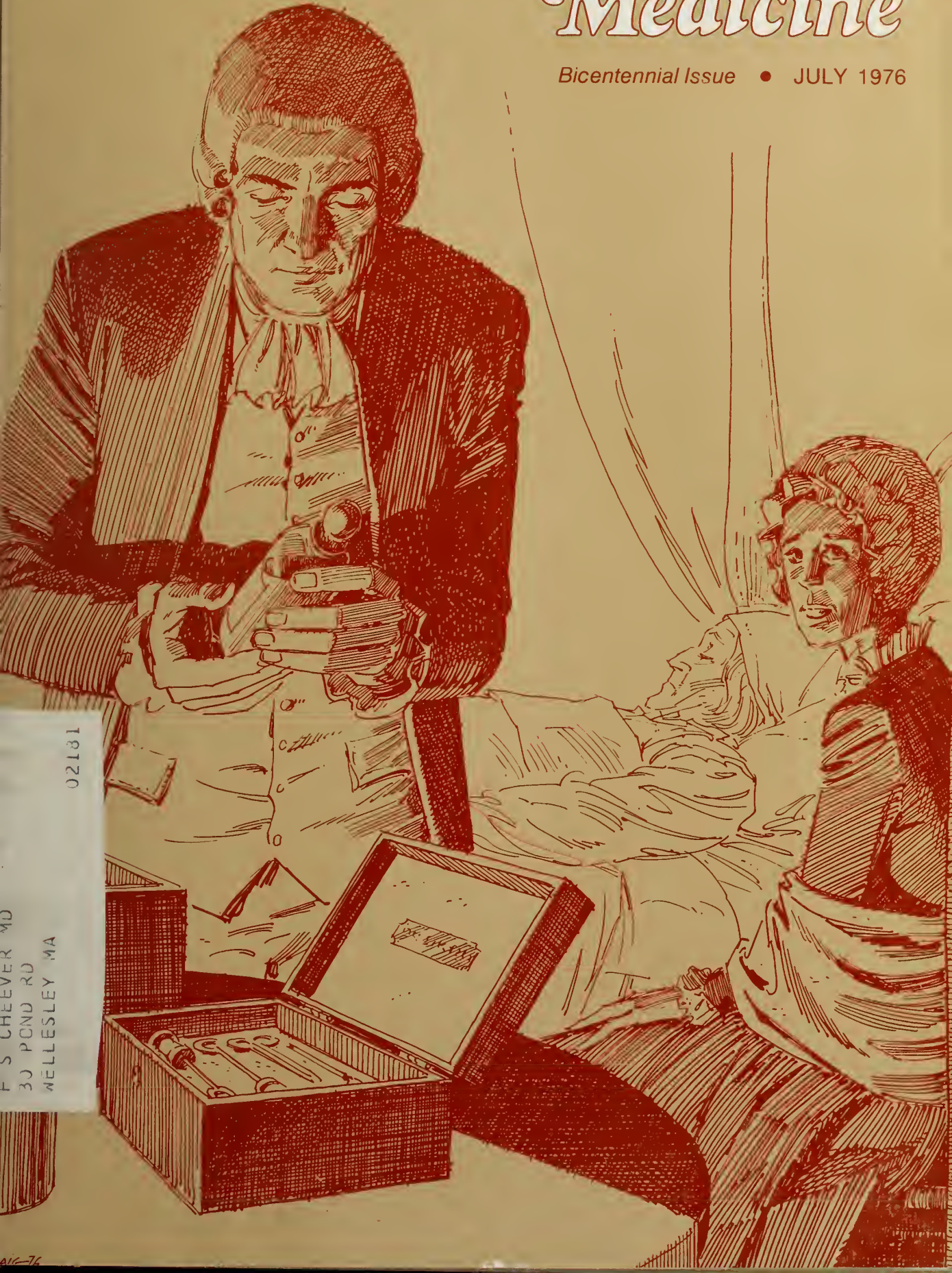
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Pennsylvania Medicine

Bicentennial Issue • JULY 1976



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Pennsylvania Medicine



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JULY 1976

VOLUME 79, NUMBER 7

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John T. Craig, of Krone Art Service, Harrisburg, executed the cover of this issue. Deborah L. Russell, editorial assistant, is responsible for researching and writing all of the news stories which tell the Society's history.

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SPECIAL SESSION CALL ISSUED The call to the one day Special Session of the House of Delegates July 11, 1976, at the Penn Harris Motor Inn, Camp Hill, has been issued. The single subject of this session is "recommendations concerning the creation of a captive insurance company." Society President David S. Masland, M.D., in a letter dated June 22 to the entire membership, reported the background of the captive company proposal and urged members to come and speak at the reference committee hearing. Members of this one reference committee are: Ralph J. Stalter, M.D., chairman (Allegheny), Betty L. Cottle, M.D., (Blair); Wayne W. Helmick, M.D., (Beaver); Robert M. Jaeger, M.D., (Lehigh); Donald M. Parlee, M.D., (Bucks); and Milton M. Perloff, M.D., alternate, (Philadelphia).

ARGONAUT POT BOILS The overall 42 percent rate increase (some 200 percent for Classes I and II) filed by Argonaut with the Insurance Department on March 11 is still pending. On April 1, with "intervenor status" PMS attorneys and actuary began six days of testimony and interrogation of Argonaut before the Insurance Department. The Society refused to support the Argonaut rate increase. On May 11 Argonaut exacerbated the crisis by unilaterally increasing its rates without Insurance Department approval. This was attempted under the "deemer" clause which says that if the Insurance Department has not acted within 60 days, a company can "deem" the new rates to be in effect. Immediately Society attorneys filed a complaint and Insurance Commissioner Sheppard stopped Argonaut from "deeming" the new rates. A hearing on the "deemer" issue was held June 21 with additional briefs still to be filed. On June 25 Argonaut billed policyholders for the third quarter and gave them only 10 days in which to pay. Argonaut also said payment was a tacit agreement to pay retroactively the new proposed rates should they be approved by the Insurance Department. Society legal counsel termed the Argonaut demands "illegal," an opinion confirmed by Insurance Commissioner William Sheppard in his letter of June 29, 1976, to Argonaut. In a letter to PMS members insured by Argonaut, Society President David S. Masland, M.D., assured policyholders that they can if necessary use the customary 30 days from July 1 to pay their premiums and that Argonaut may not retroactively raise a rate on which a premium has already been paid.

CHIROPRACTORS NOT IN BLACK LUNG PROGRAM The Governor's Advisory Committee on Pennsylvania Coal Workers' Respiratory Disease met on June 10 to discuss Governor Milton J. Shapp's proposal that chiropractors be included in the state's black lung program. The meeting came shortly after the Society publicly attacked the proposal and called on the Governor for such a meeting. Dr. Masland, society president, told the committee that the Society was "unalterably opposed to the use of a state-funded specific disease oriented program including chiropractic as an officially accepted modality of treatment for that disease." He left a seven page official position with the committee as well as a paper by Edgar L. Dessen, M.D., Hazleton, chairman of the American College of Radiology's Task Force on Pneumoconiosis. The committee, which includes ten physicians, determined to make no change in the program and to study the matter further at its September meeting. Dr. Masland said the Society was prepared to go to court if necessary to block chiropractors from the black lung program.

SUIT BROUGHT IN PHILADELPHIA HSA DISPUTE The steering committee for the Southeastern Pennsylvania Health Systems Agency has filed suit in Federal District Court challenging the right of the Department of Health, Education, and Welfare (HEW) to split the originally designated Health Service Area (Philadelphia, Bucks, Chester, Delaware, and Montgomery) into three smaller areas. Governor Milton J. Shapp, at the request of medical societies, organized labor, and local government officials, petitioned HEW Secretary H. David Mathews to make the change and he acceded. The three area designation was published in The Federal Register shortly after filing of the suit. As shown on a map in the April issue of this magazine, Philadelphia is Area I, Chester and

Delaware Counties are Area X, and Montgomery and Bucks Counties are Area XI. The state of North Carolina has filed a suit in Federal Court there to test the constitutionality of P.L. 93-641, the Health Planning Resources and Development Act, which establishes the Health Service Areas, and the American Medical Association has petitioned the court to join in the suit.

DR. ROWLAND ELECTED TO STATE COMMITTEE POST George A. Rowland, M.D., chairman of the Society's Board of Trustees, has been elected vice chairman of the Commonwealth's Swine Flu Advisory Committee. The Committee will advise Secretary of Health Leonard Bachman, M.D., on all aspects of implementation of the immunization program in Pennsylvania.

CASE TESTS MANDATORY MALPRACTICE INSURANCE On June 15 the State Board of Medical Education and Licensure met and considered the question of whether or not a physician must have professional liability insurance to practice medicine as required by Act 111. The test was brought by the case of Orlo G. McCoy, M.D., of Canton, a member of the State Society's Board of Trustees representing the Twelfth District. The board of licensure determined to hold a hearing on the matter for Dr. McCoy during its September meeting. The State Society has requested that this be the test case and that no action be taken against other physicians until this case is adjudicated. Society legal counsel presented the matter to the board of licensure.

FOUNDATION FUNDED FOR ANOTHER 15 MONTHS The Pennsylvania Medical Care Foundation has received a contract from the Department of Health, Education, and Welfare to continue as a Professional Standards Review Organization support center for another 15 months, beginning July 1, 1976. The contract is for \$215,915. The most recent Foundation activity is the coordination of the data processing systems for seven of the Pennsylvania PSROs and for one in the state of Delaware. The Foundation's new Long Term Care Committee held its first meeting in June. A full report will appear in the August issue of this magazine.

MALPRACTICE ACT CORRECTIVE AMENDMENTS INTRODUCED S.B. 1569, corrective amendments to Act 111, was introduced June 8 and has been reported out of the Insurance Committee. The amendments would permit physicians to self insure; permit the administrator of arbitration panels to "consider and approve offers of settlement for fiduciaries, minors, or incompetent parties at any time prior to the first meeting of the arbitration panel;" expand the arbitration panel's jurisdiction to include non-health care providers who may be joined in a suit; and require physicians with more than 50 percent of their practices out of the state to carry insurance coverage of \$200,000/\$600,000, but exempt them from the Catastrophe Loss Fund.

DRIVER ANATOMICAL GIFT OKAYED With the signing of the new Motor Vehicle Code by the Governor the Society achieved another legislative objective. Under the new vehicle code any person who is registered as an anatomical organ donor may attach his donor card to the reverse side of his driver's license. The code also permits attachment of information relating to a driver's personal medical history. In recent weeks the Governor also signed the tv tube safe disposal bill requested by the PMS House of Delegates. The law makes it a crime to discard or abandon a television picture tube or a set containing a picture tube which has not been neutralized to eliminate the danger of implosion.

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Bicentennial Issue – July 1976

Both often



Predominant
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anxiety

Associated
depressive
symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor

neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive dis-

orders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anti-convulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

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According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

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Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



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(diazepam) [Ⓢ]

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of child-bearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies.

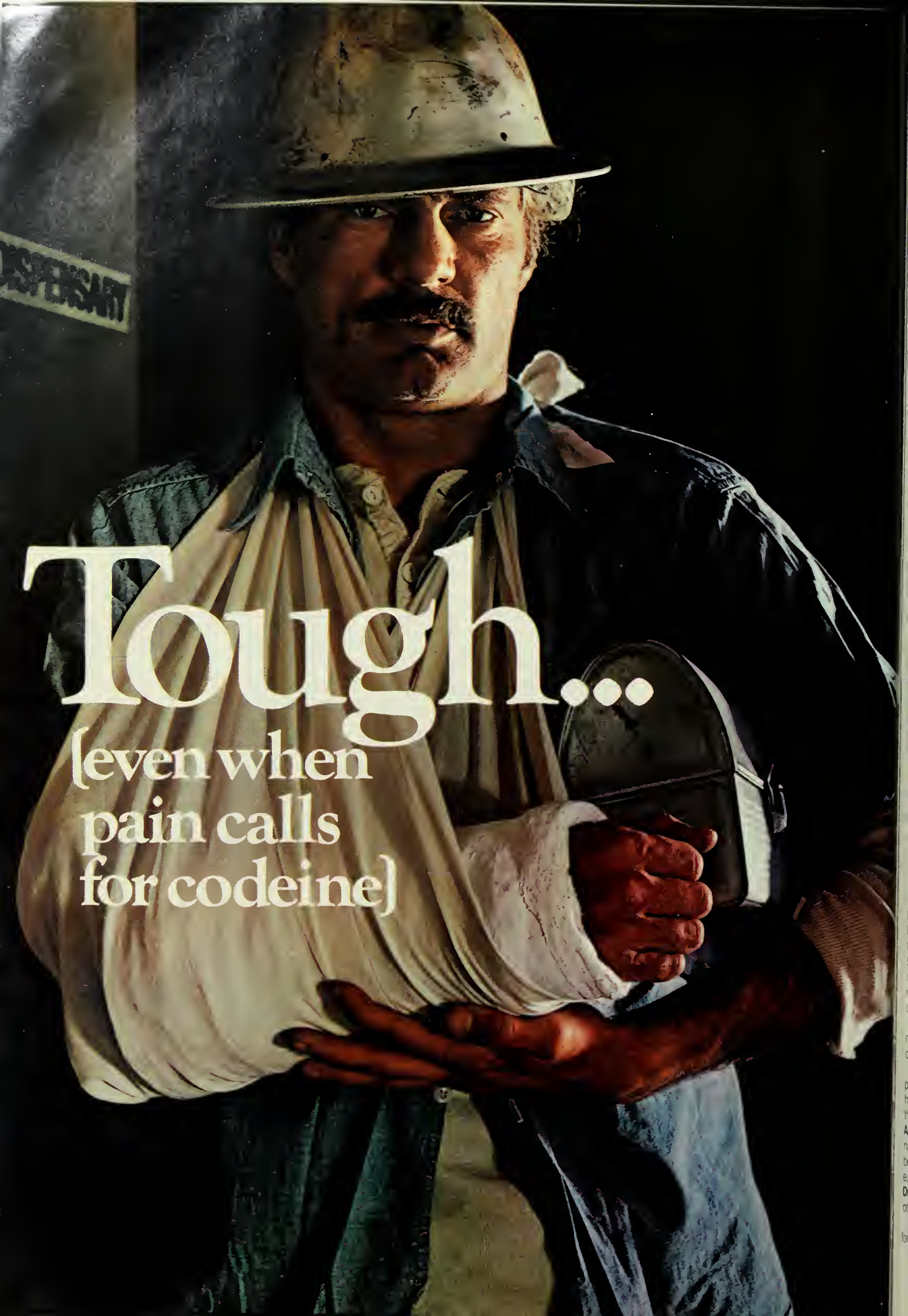
Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle

spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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for codeine)

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Usage in Pregnancy. Safe use is not established. Should not be used in pregnant patients unless potential benefits outweigh possible hazards.

Precautions: *Head injury and increased intracranial pressure.* Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal condition. Acetaminophen and codeine or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

Special risk patients. Administer with caution to elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, or prostatic hypertrophy or urethral stricture.

Adverse Reactions: Most frequent are lightheadedness, dizziness, nausea, and vomiting; more prominent in ambulatory than in nonambulatory patients; some may be alleviated if patient lies down; other: euphoria, dysphoria, constipation and pruritus.

Drug Interactions: CNS depressant effect may be additive with that of other CNS depressants. See Warnings.

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*Mielke, C.H., et al. JAMA
235:613 (Feb. 9) 1976.

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THE AMERICAN MEDICAL ASSOCIATION organized in 1847 at the Academy of Natural Sciences, Philadelphia. (Photo courtesy of Parke-Davis.)

From the signing of the Declaration of Independence in 1776 to the current search for a system of providing the best possible health care for the most people at the lowest cost, physicians have played an active and often influential part in the progress of the nation and the states.

During the early days of America's history, and prior to 1847, when the American Medical Association was formed, organized medicine did not exist as it does today. Individual physicians, such as Benjamin Rush, Philip Syng Physick, and John Morgan, emerge as prominent figures in early state and national history.

By the late 1700s, physicians had begun to organize in Pennsylvania on the county or district level in an effort to solve collectively some of the more evident health problems. Medical societies in existence prior to 1848 were the College of Physicians, 1787; the Philadelphia Medical Society, 1796; the Warren County Medical Society, 1821; the Medical Faculty of Berks County, 1824; the Franklin County Medical Society, 1825; the Chester County Medical Society, 1828; the Susquehanna County Medical Society, 1838; the Mercer County Medical Society, 1843; the Lancaster City and County Medical Society, 1844; the Schuylkill County Medical Society, 1845; the Northern Medical Association of Philadelphia, 1847; the Lebanon County Medical Society, 1847; the Mifflin County Medical Society, 1847; and the Medical Faculty of Montgomery County, 1847.

After the formation of the State Society, organized medicine began to focus on more far-reaching problems and turned to the Legislature, in which there were a number of physician members, for assistance.

This special issue of PENNSYLVANIA MEDICINE is presented as a bicentennial reminiscence. In it the reader will find short pieces focusing on specific events, which have highlighted the progress of the Society, followed by more comprehensive articles which help to put the Society's history into greater perspective.

In the following pages, which do not begin to give medicine's entire history in the state, the reader is likely to find a certain amount of relevance to his life and experience in modern medicine.

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State Medical Convention Meets

LANCASTER, APRIL 1848. Eminent medical gentlemen from throughout the Commonwealth assembled Tuesday and Wednesday, April 11 and 12, in the Methodist Episcopal Church, North Duke Street, to participate in the State Medical Convention called for the purpose of forming a State Medical Society. Gentlemen from the counties, the University of Pennsylvania, the Jefferson Medical College, the Franklin Medical College, the Pennsylvania Medical College, the Philadelphia College of Medicine, the Philadelphia Association for Medical Instruction, and the College of Physicians of Philadelphia, sixty-one in all, met pursuant to invitations extended jointly by the medical societies in Chester County and Lancaster County.

Initiating action to organize a State Medical Society was a resolution, offered by Dr. Wilmer Worthington during the December 1, 1847, meeting of the Chester County Medical Society, stating:

"Whereas, No state medical society exists in Pennsylvania; and believing that such an institution would greatly contribute to the advancement of medical knowledge within its bounds; therefore

"Resolved, That it is expedient to hold a convention at such time and place as may be hereafter agreed upon.

"Resolved, That the corresponding secretary be directed to forward a copy of these proceedings to the different medical schools and associations in the Commonwealth, and solicit their early cooperation."

Upon receipt of the recommendation, members of the Lancaster County Medical Society with great enthusiasm elected delegates and issued a proposal for the use of Lancaster as the convention site, which was agreed to.

Following the verification of the credentials of seated delegates, officers were chosen for the purpose of the permanent organization of the Convention. Dr. Samuel Humes, of Lancaster County, was approved as President. Dr. John P. Heister, of Berks

County, and Dr. Thomas Wood, of Lycoming County, became Vice Presidents, and Dr. Alfred Stillé, of Philadelphia, and Dr. G. Z. Dimock, of Susquehanna County, were named secretaries of the Convention.

During the Wednesday morning session of the convention, subsequent to choosing officers for organizational purposes, Drs. Gouverneur Emerson and Henry Bond, of the Philadelphia Medical Society, John L. Atlee, John K. Eshelman, and Samuel Duffield, of the Lancaster City and County Medical Society, Isaac Hays, of the College of Physicians of Philadelphia, and Samuel H. Harry, of the Chester County Medical Society, were appointed to draft a Constitution and Bylaws for a State Medical Society.

The appointed Committee acted swiftly. The Convention having reassembled at 3½ o'clock, P.M., after a recess of a few hours, Dr. Hays, as Chairman, presented the report of the

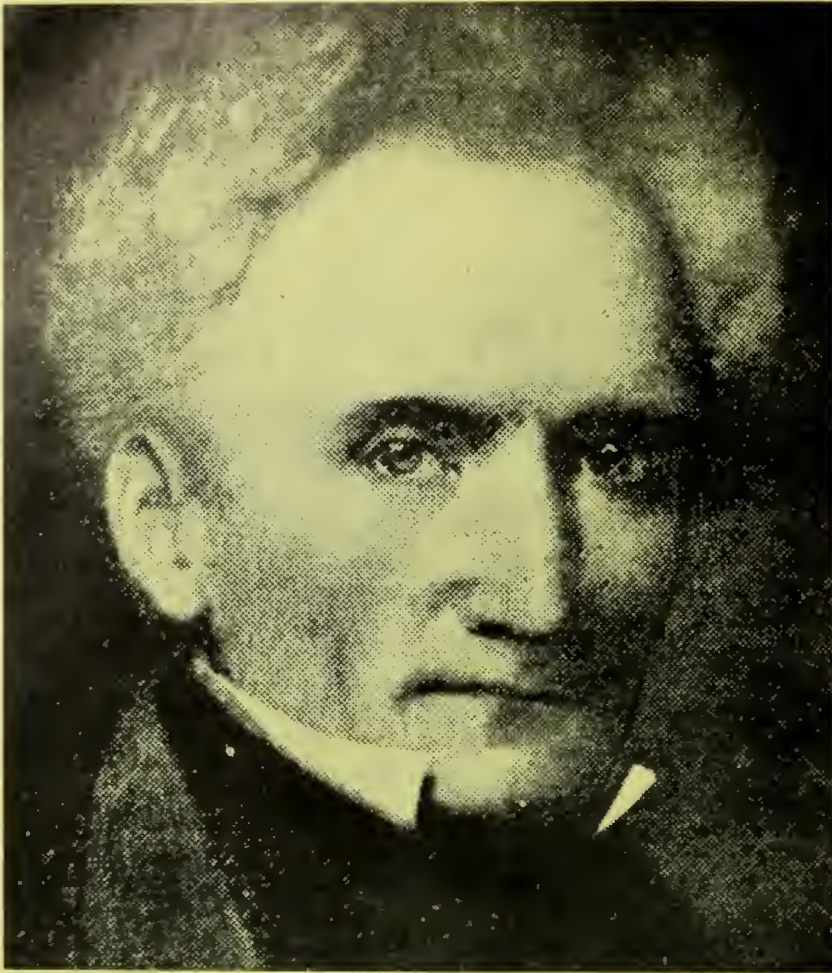
Committee to draft a Constitution and Bylaws. The proposed items to be contained in the documents were discussed thoroughly and voted upon one at a time.

As approved by the State Medical Convention, the objects of the Medical Society of the State of Pennsylvania "... shall be the advancement of Medical knowledge; the elevation of professional character; the protection of the interests of its members; the extension of the bounds of Medical Science, and the promotion of all measures adapted to the relief of suffering, and to improve the health and protect the lives of the community."

Members of the Medical Society shall be either delegates or associates, delegates being appointed by the County Societies. Members must be graduates of a respectable Medical School, or possess licenses to practice from some Board recognized by the State Society, or have been practition-



METHODIST EPISCOPAL CHURCH, Lancaster, 1848.



DR. SAMUEL HUMES, of Lancaster County, elected first State Society President in 1848.

scribes a remedy without knowing its composition, or who shall hereafter give a certificate in favor of a patent remedy or instrument, shall be disqualified from becoming a member of a County Society."

Upon adoption of the Constitution and Bylaws, the Medical Convention resolved itself into the Medical Society of the State of Pennsylvania and proceeded to the election of the first officers for that body, to consist of a President, four Vice Presidents, a Corresponding Secretary, two Recording Secretaries, and a Treasurer.

Dr. Humes was elected to remain President until the next meeting of the Medical Society next April. Drs. Heister and Wood were retained as Vice Presidents, to serve with Dr. Samuel Jackson (Professor), of Philadelphia, and Dr. John L. Atlee, of Lancaster. Dr. Isaac Hays, of Philadelphia, was chosen as the Corresponding Secretary while Dr. H. S. Patterson, of Philadelphia, and Dr. George B. Kerfoot, of Lancaster, became Recording Secretaries. Dr. George Fox, of Philadelphia, assumed the duties of the office of Treasurer.

Just prior to adjournment, it was resolved to request the various County Medical Societies "to procure the registration of names of all regular practitioners in their respective limits," and transmit a list of the names to the State Society at the next meeting, to be held in Reading, on the Second Wednesday of April, 1849, as no such registration has been carried out in the State.

ers for at least fifteen years.

Delegates further voted to require that "Any Physician who shall procure

a patent for a remedy, or Instrument of Surgery, or who sells or deals in patent remedies or nostrums, or who pre-

Registration Bill Passes Legislature

HARRISBURG, MARCH 1851. Bill Number 649, A Bill Relative to the Registration of Marriages, Births, and Deaths, has been passed by a large majority of both houses of the State Legislature. The legislation would require each county register of wills to register marriages, births, and deaths occurring within his county from and after the first day of July. Every physician is responsible for reporting births and deaths, which he witnesses, to the county register.

The Committee on the Registration of Births, Marriages, and Deaths, which was formed by the Society in April 1849, was largely responsible for designing and initiating action by the Legislature, with the valuable aid of the Honorable Edward Armstrong, a Representative of the City of Philadelphia.

Dr. D. Francis Condie, of Philadelphia County, Chairman of the Committee, said in a report to the Society's House of Delegates, "The bill, al-

though it does not, in all its details, coincide with the views of the Committee, was the best they could obtain, and they believe that the amendments required to secure its efficient working could be easily obtained, should it become law. The Committee regret to say that the bill has not yet been approved by the Governor."

Should the bill become law, it will be the duty of every physician or surgeon to keep a record of births and deaths, taking place in his presence, in a book

for that purpose, and return the same, in the form of a certificate, signed by him, to the county register within thirty days. Each clergyman is so responsible for the reporting of marriages performed by him.

Books for the purpose of registrations will be especially designed and printed with titles, duly numbered, opposite to which will be spaces for entries. Marriages, Births, and Deaths must be kept in separate books.

The Register will receive the sum of ten cents, on his demand, from the treasurer of the proper county for registering any marriage, birth or death unless occurring prior to the year 1851, for which registrations he will receive twenty-five cents.

State Registers 6,395 Physicians

TITUSVILLE, MAY 1882. Dr. R. L. Sibbet, Chairman of the State Society's Committee on Medical Legislation, during the Annual Meeting, presented the first statistics available relative to the registration of physicians as required by The Registration Act, having been signed into law last year.

The total number of graduates of the various medical schools in the State is 3,947, including 66 females. Graduates from other states' medical schools number 1,610, including 12 females. Foreign graduates who complied with

the Registration Act number 97, with 5 females. Registered non-graduates of medical schools who have practiced ten years or longer total 838, with 23 females. An estimation of 295 was made of the possible number of non-registered physicians in the state. However, a substantial number of counties were unable to estimate the number of physicians not registered under the Act.

In making the report to the House of Delegates, Dr. Sibbet stated, "With large numbers of bristling doctors in the field, armed with bogus diplomas, obtained from chartered institutions in our own and other States—eclectics, homeopaths, hypno-theraputists, vitopaths, electricians, and irregulars of every description—what could your Committee have done, more than has been done? By the use of means which no gentlemen in the profession would think of using, these pretentious classes of practitioners have made an impression upon the people, that they are the pioneers in medical science and art. Calling themselves *new-school* practitioners, and applying to us the odious epithet, *allopathic*, they go from house to house, advocating their theories and soliciting trade.

"Unfortunately, too, our Representatives carry with them into the Assembly of the State the theories and sentiments of these men; so that your committee have not dared to ask that restraints be placed upon any practitioner representing a chartered medical school. Nor have we dared to ask, that the non-graduate class of practitioners in our State be brought before a board of medical examiners. These and other branches of this complex subject, remain to be considered, and acted upon by our Legislature, though it is certain that the non-graduating class must soon disappear under the faithful execution of the present law; and we have reason to believe from the experience of a few counties, that a little pressure and firmness on the part of the county medical societies will drive many of the bogus-diploma practitioners out of the State."

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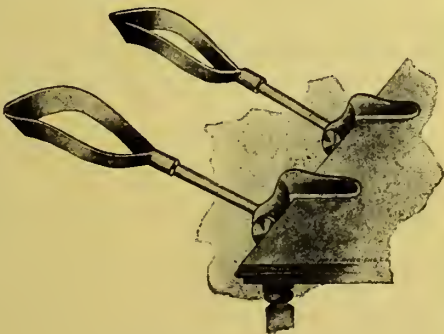
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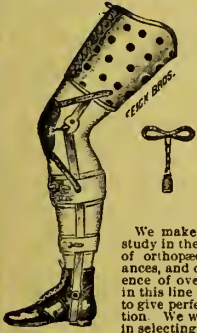
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State Board of Health Approved

HARRISBURG, MAY 1885. The creation of a State Board of Health and Vital Statistics, for the purpose of statewide sanitation, has been approved by both Houses of the Legislature, needing only the Governor's signature.

The new Board "... shall have the general supervision of the interests of the health and lives of the citizens of the Commonwealth, and shall especially study its vital statistics. It shall make sanitary investigations and inquiries respecting the causes of disease, and especially of epidemic diseases, including those of domestic animals, the sources of mortality, and the effects of localities, employments, conditions, habits, food, beverages, and medicines on the health of the people. ..."

The Board will also be responsible for the registration of all marriages, births, and deaths occurring in the Commonwealth.

It will consist of six persons, the majority of whom shall be physicians in good standing, graduates of regularly chartered institutions, and of not less than ten years' experience in the practice of medicine, and one civil engineer, and a secretary, who will be the executive officer.

Additionally, the Board must report each December to the Governor concerning the sanitary conditions in the Commonwealth.

Efforts to secure passage of such a Board of Health bill, which began in 1877, were often discouraged by the Legislature. Many of the legislators who are members of the medical pro-

fession feared the effects of such regulation upon the practice of medicine.

During the winter session of 1883, a bill similar to the one which now has been passed, was lost, according to the report made by the Committee on a State Board of Health, as the result of an amendment "... proposing to recognize by name and to make it obligatory upon the Governor to appoint upon the Board the adherents of an exclusive dogma in medicine. This was, of course, stoutly resisted by the medical members of the Legislature, who very properly preferred to see the bill fall rather than to have it pass with such a palpable blot upon its face. ..."

However, the State Society's efforts, and especially the unabating energies of the Honorable Robert Adams, Jr., of the Senate, and the Honorable H. K. Boyer, of the House of Representatives, unable to be discouraged, secured the bill's passage.

Governor Appoints Examining Boards

HARRISBURG, JANUARY 1894. Governor Pattison, under the new Medical Law of Pennsylvania for the examining and licensing of physicians, signed by him May 18 of last year, has appointed members of the Medical Examining Board to represent this Society. They are Drs. H. G. McCormick, Williamsport, for three years; Henry Beates, Jr., Philadel-

phia, for three years; W. J. K. Kline, Greensburg, for three years; W. S. Forster, Pittsburg, for two years; J. E. Silliman, Erie, for one year; and Samuel W. Latta, Philadelphia, for one year. Dr. McCormick was chosen President by the members of the Board.

Medical Examining Boards to represent the Homeopathic Medical Soci-

ety and the Eclectic State Medical Society were also appointed.

The Medical Council, which will authorize licensing of all applicants, consists of Dr. McCormick, by virtue of his position as President, the Presidents of the other Medical Examining Boards, the President of the State Board of Health and Vital Statistics, the Attorney General, the Superintendent of Public Instruction, the Lieutenant Governor, and the Secretary of Internal Affairs. Together they will supervise the examination practices of the three examining boards and issue licenses to applicants who have passed examination.

Applicants may choose the Board by which they wish to be examined. The examinations administered by the Boards are identical except in the areas of materia medica, therapeutics, and practice of medicine.

The first examinations, under the new law, of physicians desirous of beginning medical practice in Pennsylvania will be held June 11, 1894, at Pittsburg and Philadelphia, locations of which will be announced at a later date.

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Dr. Dixon First Health Commissioner

HARRISBURG, JUNE 1905. Governor Pennypacker has appointed Dr. Samuel G. Dixon, President of the Academy of Natural Sciences, in Philadelphia, as the first Commissioner of the newly created State Department of Health. Dr. Dixon as Commissioner replaces the State Board of Health and will receive a salary of \$10,000.

The Commissioner is empowered to issue subpoenas and compel witnesses to testify in any matter to him, and to issue warrants for the arrest of per-

sons who disobey quarantine orders or the regulations of the Department of Health. In the abatement of nuisance which threaten the health of communities the commissioner will have almost unlimited authority.

The new Act requires that an advisory board of six members, the majority of whom must be physicians, be appointed. Governor Pennypacker has appointed the following members to the Board: Dr. Charles B. Penrose, Philadelphia; Dr. Samuel T. Davis, Lancaster, former member of the as-

sembly and President of the State Board of Health; Leonard Pearson, Philadelphia, State veterinarian; Dr. Adolph Koenig, Pittsburg, President of the Medical Society of the State of Pennsylvania; B. H. Warren, West Chester, State Dairy and Food Commissioner; and Lee Masterson, Johnstown, civil engineer.

The bill provides that the state be divided into ten districts, each district to be in charge of a physician of five years' practice, who shall receive a salary of \$2,500 a year.

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The Official Organ of the Medical Society of the State of Pennsylvania.

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Physicians to Report Diseases

HARRISBURG, DECEMBER 1905. Contagious Diseases to be Reported. A circular letter of instructions has been sent to physicians by the State Commissioner of Health giving a list of the diseases which they are required to report to the board of health of the city or borough in which the disease occurs. The list is as follows: Actinomycosis, anthrax, bubonic plague, cerebrospinal meningitis, chickenpox, cholera, diphtheria, epidemic dysentery, erysipelas, German measles, glanders, hydrophobia, leprosy, malarial fever, measles, pneu-

monia, puerperal fever, relapsing fever, scarlet fever, smallpox, tetanus, trachoma, trichiniasis, tuberculosis, typhoid fever, typhus fever, whooping cough, and yellow fever. The so-called "membranous croup," "diphtheric croup," or "putrid sore throat," is to be reported as diphtheria, and the so-called "scarlatina" and "the scarlet rash" as scarlet fever. Blanks for reporting such diseases can be obtained by applying to Department of Health, Harrisburg, Pa., the State paying postage for these notices.

practice," or limited practitioners, under the control of the Bureau as regards their education and license. It provides for reciprocity with other states and for revocation of license, and it repeals all conflicting former laws. The osteopaths are specifically exempted from the provisions of the Act.

The Bureau of Medical Education and Licensure will be established as part of the Department of Public Instruction and will consist of seven members, two of whom, the Superintendent of Public Instruction and the Commissioner of Health, will be *ex officio* members. The five remaining members are to be selected from legally incorporated medical societies in the State, namely one from this Society, one from the State Homeopathic Medical Society, one from the State Eclectic Medical Society, and the remaining two from other legally incorporated schools or systems of practice.

The Bureau is empowered to supervise the teaching facilities and standards of the medical educational institutions chartered in the State. Standards to be upheld by institutions include a general preliminary education of not less than a standard four years' high-school course or its equivalent and a graded medical and surgical course of four years, each of which shall be of not less than thirty-two weeks of not less than thirty-five hours each week of actual work in didactic, laboratory, and clinical study in different calendar years.

Failure to conform to authorized standards will render graduates of offending institutions ineligible until such time as the instruction and course are made to the standard adopted.

The Bureau may refuse, revoke, or suspend the right to practice medicine or surgery for the conviction of a crime involving moral turpitude, or for habitual intemperance in the use of ardent spirits or stimulants, narcotics or any other substance which impairs intellect and judgment to such an extent as to incapacitate for the performance of professional duties.

A careful study of the Act will show that it has accomplished a very long step towards the betterment of social conditions and the protection of qualified physicians.

Do You Know Samuel Barnes?

ATHENS, AUGUST 1905. Do you know Samuel Barnes, sometimes known as Edward S. Barnes or Edward Barnes? He registered in Westmoreland County under the act of 1881, and recorded seventeen years of continuous practice from 1871 to 1888, as follows: Sandy Lake, four years; Jackson Township, five years; Sheakleyville, three years, and Stoneboro, five years, all in Mercer County. His registration was a few months previous to his conviction of arson and sentence to imprisonment in the Western penitentiary for nine years. It is intended to show that this individual never practiced at these places. The physicians of Monessen invite all physicians who know of this man and who can give any evidence or the names of persons who could do so, to communicate with their attorney, A. M. Weyant, at Greensburg, or with Dr. Arthur R. Wilson, Monessen.

Medical Practice Act Passes

HARRISBURG, JUNE 1911. The Gerberich Bill, or the Medical Practice Act, has passed the Legislature and has been approved by the Governor.

The bill as it finally passed may properly be called a composite bill. It gradually developed while under the control of the Society's Committee on Legislation and Public Policy; it incorporates the good features of the bill introduced by Senator Tustin, and it preserves the essential features of the Wolf Bill, from which it grew.

The Act indicates who may practice medicine in the State. It creates a Bureau of Medical Education and Licensure, and prescribes its membership and the terms of service. It defines the functions and duties of the Bureau. It prescribes definitely the preliminary and technical education necessary for license as a practicing physician in the State.

Second, it places medical schools under the supervision of the Bureau. It places so-called "branches of medical

Pennsylvania Had First Medical School

PHILADELPHIA, JANUARY 1911. The Medical Alumni of the University of Pennsylvania have recently convinced themselves that that University had a full-fledged medical school at least a year before Harvard's was organized.

Dr. John Morgan was born in Philadelphia in 1735 and graduated from the University of Pennsylvania in 1757. He then went abroad and earned his degree as doctor of medicine from the University of Edinburgh in 1763. He studied in Germany, it is said, and on returning to America in 1764 began the practice of his profession in Philadelphia. He was the first to recognize the necessity for a medical school in this country and established one on Chestnut Street near Sixth, just across the street from Independence Hall. After getting it under way he decided that he owed it to posterity to have the University take over the youthful institution and persuaded the trustees to do so, himself taking the comparatively humble post of pro-



THE SCHOOL OF MEDICINE at the College of Philadelphia, Fourth and Arch Streets, was the first medical school in the Nation.

fessor of chemistry. This he held until the Revolutionary War, when he was called on to organize the medical corps of the Continental Army, which post he held until failing health forced him to resign, but not before he had put the

corps on a firm basis. He lived until 1789 and was honored by every learned society in the city, state and country for his invaluable service to the cause of country and the future of medicine.

Commission Designs Medical Expert Bill

PITTSBURGH, OCTOBER 1914. The Commission on Medical Expert Testimony, appointed during the annual meeting of 1913, has designed a model bill to be presented to the Legislature "to protect corporate bodies from unscrupulous attorneys and close the wide-open door upon the crooked expert."

Seventeen symposia were held by the Commission jointly with various county societies to confer with members of the legal profession regarding the errors existing in the present method of giving and taking expert testimony.

The members of the Commission gathered suggestions made during the symposia and organized them into a system providing for accurate expert testimony. Study of the reports of the symposia emphasizes that it is the unanimous opinion of both the medi-

cal and legal professions that the correction of the conditions surrounding the expert is a vital necessity to preserve the integrity of both professions.

Particularly helpful to the Commission was Judge G. A. Endlich, of Reading. His suggestions, because of their simplicity and practicability and because of the good results which would ensue, were used as guidelines by the members of the Commission. They are: "(1) The formulation of a stricter definition of expert capacity; (2) The reasonable limitation of the number of experts to be called in any case; (3) The designation of such experts by the court upon nomination by the parties; (4) The abolition of the hypothetical question; (5) The summoning by the trial judge of an expert of his own choice to serve as assessor, or as witness to review the expert testimony already in, or as both; and (6) The

payment of expert witnesses out of the public treasury, at least in the first instance."

According to the model bill, no one

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shall be eligible to testify "unless it is first shown (1) that the subject matter concerning which he is to testify is fairly within (a) his present principal avocation in the locality in which he follows the same, or (b) the operation of an invention made by him and reduced to actual working, or (c) a line of study or investigation, not ordinarily pursued as a distinct profession or business, in which his researches have been systematic or his opportunities for observation exceptional; (2) if the question involved be one not of purely abstract science, that his experience has been both practical and theoretical; (3) if the subject is one of professional study or science, that he is familiar with the most advanced learning upon the same; (4) if, in the local-

ity in which the proposed witness resides or follows his avocation, or where the trial, etc., is had, the subject is one generally pursued as a medical, surgical, or pathological specialty, that he presently so pursues it; (5) that he has not been approached, consulted, employed or paid with reference to the trial on any question involved in it, by either party to the same, or by any one in behalf and by authority of said party, nor (except by way of authorized report to the court) expressed an opinion concerning any such question as applicable to the case on trial.

All expert witnesses shall be called by the Court at the request of either or both parties or at the will of the presiding judge. All expert witnesses must either be in attendance during

the entire trial or be furnished with a copy of the testimony delivered prior to his appearance.

Payment for court appearances by expert witnesses is to be made from the county treasury, "possibly with the proviso that the amount thereof, or some proportion of it, be charged as part of the costs of the proceeding and repaid to the county by the party or parties liable, upon final decision, for payment of costs."

The model bill will be presented to the Legislature at its next session.

(Editor's Note: After its introduction into the Legislature, the bill was referred to the Judiciary Committee, which reported a negative recommendation.)

Society Purchases Headquarters Building



HARRISBURG, DECEMBER 1922. The Board of Trustees has purchased an improved property, for the purpose of carrying out State Society business, located at 230 State Street, in Harrisburg. For some years many members of the Society have visualized the need of a permanent location for the office of the State Journal and such other offices as may be appropriately placed in a central location.

The building is a three-story brick of old style and construction, erected prior to 1857, situated on a lot twenty-six by one hundred thirteen feet, to a ten-foot private alley on State Street, six doors from the corner of North Third Street, being on the boulevard leading from the entrance to the Capitol grounds to the Susquehanna River. The expense, including improvements to suit the purpose of the Society, will be approximately \$21,000.

As soon as it is prepared for occupancy, the building will be used by the Executive Secretary and Editor of the Journal, and the upper floors will be offered for rent. Society officials hope that the permanent location of offices will increase the interest in all the activities which surround the organization.

THE BUILDING at 230 State Street, as purchased by the Medical Society of the State of Pennsylvania in December 1922.

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avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **REFERENCE:** Robert * B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Vitamin B-12	1.5 mcg

Methionine	12 mg
Choline Bitartrate	15 mg
Inositol	10 mg
Calcium Pantothenate	2.5 mg
Pyridoxine	0.25 mg
Copper (from Copper Sulfate)	0.25 mg
Zinc (from Zinc Oxide)	0.25 mg
Iodine (from Potassium Iodide)	0.075 mg
Calcium (from Dicalcium Phosphate)	72.5 mg
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Freeman Commission Organizes

PHILADELPHIA, NOVEMBER 1927. The Commission to Study Laws Relating to the Healing Art, or the Freeman Commission, organized at the Bellevue-Stratford Hotel, Philadelphia, November 16. The Commission was appointed by Governor John S. Fisher in accordance with a resolution, known as Act 396, passed by the last session of the Legislature.

The members of our Society will recall that at the recent session of the Legislature the Society introduced a One Board Bill to govern the practice of the healing art in the Commonwealth. Bills were also introduced by the various cults to govern their respective activities. Because of the great difference of opinions on the matter, particularly between organized medicine and chiropractic, the Legislature finally adopted a joint resolution to create the Commission. Senator William C. Freeman is chairman of the Commission, the Honorable James J. Heffernan is vice chairman, and Dr. Francis D. Patterson, of Philadelphia, is secretary treasurer.

Following the formality of organization, the first public hearing was begun. Senator Freeman announced the purpose of the Commission to be the study of laws regulating the practice of the healing art, as used by the various states of our own country and of foreign countries; the study of this subject as it pertains to the local condition in this State; and the formulating of conclusions to be presented to the Legislature at the session of 1929 for the purpose of enacting a law or laws to remedy the chaos which now exists.

The afternoon session was opened by our president, Dr. A. C. Morgan. He outlined the needs for proper regulation. He presented official communications from the State Department of Education citing practitioners in the State who were not licensed. This evidence brought forth responses from the audience, as some of those whose names were mentioned were present and had presented arguments at the morning session. Our secretary, Dr. Walter F. Donaldson, presented voluminous documentary evidence outlining the position of our Society, and

read abstracts from these communications.

The hearing was continued to the following day. Among those heard were the Chiropractic school, which presented their plea for a separate board of examiners, claiming that it was unfair for any one except a chiro-

practor to judge the qualifications of chiropractors.

The next public hearings of the Commission will be in Pittsburgh on January 16 and 17, 1928. Another session will be held in Scranton at a date to be announced later. These meetings are open to the public.

Facts Misrepresented

PITTSBURGH, FEBRUARY 1928. The brief presented to the Freeman Commission by the Pittsburgh Health Club, an organization officered by and enrolling optometrists, osteopaths, food faddists and antivaccinationists, under the heading "Wholesome Confessions," quotes in part from addresses delivered by well-known physicians. Subjects critically and constructively discussed in full are, when by piecemeal quotation separated from their context, distorted to the purpose of the writer of the brief referred to. When the attorney who prepared the brief of the Health Club included among "Wholesome Confessions" one he lifted from the presidential address of the late George W. Wagoner, M.D., president of our Society in 1909, he opened the way for his own undoing in public before the Freeman Commission at its Pittsburgh hearing.

Immediately preceding the quotation given in the brief, Dr. Wagoner had been discussing the faddist, the smatterer, the correspondence-school doctor—their cruel and harmful methods, their treatment prolonged while the patient's money lasts, and the waste of the "precious formative moments during which so many diseases may be checked, controlled, or cured." Immediately following the quotation, he used the words "a frenzy of action in the elimination of the incompetents from the ranks of those who assume to care for our health and lives. Conditions would soon be changed, the public would be aroused, educational requirements, medical laws would be enacted which would speedily diminish the slaughter of the innocents. What years of study might

then be exacted? What proofs of knowledge and skill might *then* be required?"

One who reads with honest purpose Dr. Wagoner's address made nineteen years ago realizes that he was leading the members of the Medical Society of the State of Pennsylvania in their fight against the pretenders of his day, which fight was begun in 1889 and climaxed in 1927 in the creation of the Freeman Commission.

Dr. Alex. H. Colwell, in his presentation before the Commission, cleverly turned the full strength of Dr. Wagoner's *complete* statement against the *incompetent pretenders* of 1927; namely, the approximately seven hundred illegal practitioners comprising the Pennsylvania Chiropractors' Association, who were represented before the Commission by the attorney who represented the Pittsburgh Health Club.

The quotation from Dr. Wagoner's address, under the heading, "Wholesome Confessions," follows verbatim as it appears in the Health Club brief:

"If the mighty host of those who have been rushed to untimely graves by . . . physicians could be marshalled into an army and marched in ghastly review before the astonished eyes of our indifferent legislators, what a ghost-like multitude of outraged victims there would be! One which would appeal by its magnitude and horror, and excite the law-makers into a frenzy of action. . . ."

The missing words in the second line are *incompetent, pretending*.

Walter F. Donaldson, M.D.
Secretary

Freeman Commission Reports Findings

HARRISBURG, JANUARY 1929. On the fourteenth of January the long-looked-for Freeman Commission Report, also known as the Healing Arts Commission Report, was returned to the House and Senate of the 1929 legislature and to the Governor. The report was signed by Blanche R. Young, Pittsburgh, Chiropractic, H. M. Vastine, Harrisburg, Osteopathic, Robert W. Berger, Etna Naturopathic, Mr. Freeman and Mr. Heffernan, of the Legislature, and lay member Mary Baer Hiester (with reservations).

Also submitted was a dissenting report signed by R. S. Marshall, M.D., E. F. Shaulis, M.D., Ross V. Patterson, M.D., and lay member John C. Ward.

The Assenting Report is a pamphlet of forty-five pages, and incorporates the resolution creating the Commission. It then proceeds with a historical review of the plan and scope of the work with a discussion of the present laws relating to the various branches of the healing art. Then follow a series of recommendations which will be introduced into the Legislature as Senate Bill Numbers 12, 13, 14, and 15.

Senate Bill Number 12 has for its purpose the appointment of another commission to codify the laws relating

to the healing art, this commission to consist of nine persons, seven of whom shall be appointed by the Governor, and shall represent the various approaches to the healing art. The bill has set forth as its purpose a desire to codify and revise the laws relating to the healing art, and to eliminate and exclude all overlapping revisions, as well as to define the "practice of medicine."

Senate Bill Number 13 is a new act which, if passed, would abolish representation by surgeons of medical training on the Osteopathic Surgeons Examining Board, which now consists of two surgeons of medical training. The reason for so doing, as stated in the Assenting Report, is that by placing on the Osteopathic Surgeons Examining Board two osteopathic surgeons, better protection and better training of those osteopathic physicians who practice surgery would be provided.

Senate Bill Number 14 is an act included in the Assenting Report raising the preprofessional standards of requirements for the medical student to two years of college study leading to a degree in arts and science, with the major work in chemistry, biology, and physics. Organized medicine, in the

Dissenting Report, concurred in this recommendation and accepted Senate Bill Number 14 as a step in the right direction.

Senate Bill Number 15, which is a supplement to the Medical Practice Act of 1911, authorizes the formation of a separate Board of Chiropractic Examiners and other similar boards, as they become necessary. It also calls for the automatic licensing of all chiropractors who have practiced in the Commonwealth for a period of five years or more, and who can show evidence to the Board of Chiropractic Examiners of being graduates of a reputable college of chiropractic. All those who have not practiced for the required five years may obtain a license by passing a reasonable examination given by the Board in the general area of chiropractic. Additionally, Senate Bill Number 15 does not restrict the type or character of practice which the chiropractors would be permitted to follow once they are licensed.

Of the package of bills to be introduced into the Legislature, Senate Bill Number 15 is the most disagreeable to organized medicine. The Medical Practice Act, passed in 1911 and amended in subsequent years, provides for the examining and licensing of chiropractors and other "cultists" who are able to meet the standards of the State Board of Medical Education and Licensure. To set up a board of chiropractors who have not themselves met the requirements and to allow them to judge the fitness of others entering the profession is in the opinion of organized medicine a harmful lowering of the standards of medical practice in the Commonwealth.

The first public hearing on Senate Bill 15 will be held on Tuesday afternoon, February 19, at 2 p.m., probably in the Chamber of the House. The time limit will be two hours, allowing an hour for both the chiropractic group and organized medicine.

(Editor's Note: A hearing was held accordingly. At the end of the 1929 legislative session, Senate Bill Numbers 12, 13, 14, and 15 had been either held in committee or had failed passage when reported out.)

An outstanding achievement in Beauty and Efficiency

THE modern physician knows how important is the impression made upon his patients by the appearance and equipment of his office. It must be more than efficiently equipped; it must properly reflect his professional standing and the character of his practice.

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For many years the Wappler Telatherm has been widely used for medical and surgical diathermy, electrocoagulation, desiccation, bladder fulguration, and autocondensation. Its high quality is indicated by the fact that it has been placed on the approved list of the National Board of Fire Underwriters.

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WAPPLER ELECTRIC COMPANY, Inc.
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State Board Sued by Chiropractors

PITTSBURGH, JUNE 1929. In the July term of the Court of Common Pleas of Allegheny County, a sitting in equity will be heard between Howard C. Long, Leo J. Steinbach, Blanche R. Young, William M. Ledger, Lillian P. Shook, and Fred S. Cothery, plaintiffs, and the members of the State Board of Medical Education and Licensure, defendants.

The plaintiffs claim that Chiropractic is complete in its principles and therapeutics, and separate and distinct from other healing professions, especially from the Allopathic, Homeopathic, and Eclectic professions. They claim further that the State Board of Medical Education and Licensure has "mistakenly and unlawfully assumed authority with respect to the granting of licenses, for the practice of an alleged profession of 'drugless therapy,' including therein the practice of Chiropractic. Your orators aver that the enforcement of said regulations is beyond the power and/or authority of said Bureau, under the said Act of 1911, its supplements or amendments."

The complaint states that if the Act of 1911 does refer to Chiropractic, it is "unconstitutional and void because the titles do not clearly give notice to the subject and substance of the acts. . . ." Finally, the plaintiffs claim that the State Board is unqualified to pass upon the licensing or regulation of Chiropractic, due to lack of knowledge of the profession.

The Chiropractors hope that the Court will declare the Act of 1911 to be in violation of the Constitutional rights of the Chiropractors. They wish the Court to rule that the Act does not purport to or in fact regulate the practice of the profession of Chiropractic, and that the State Board of Medical Education and Licensure be restrained "from enforcing the regulations . . . or any other regulations governing the issuance of license for the practice of Chiropractic, and from adopting any other regulations or plans affecting your complainants, or affecting those persons, or any other persons desiring to practice Chiropractic . . . in the Commonwealth of Pennsylvania."

It is the opinion of State Society officials that there can be no serious thought in the minds of those in the Chiropractic group that such a procedure could set aside the present Medical Practice Act of 1911, which has already been tried and retried and, in each and every instance, sustained by the Superior and Supreme Courts of this State.

(Editor's Note: The case was finally heard in October 1929. A decision handed down during the first part of 1930 denied the injunction asked by

the Chiropractor Association, legally upheld the State Board's right to formulate regulations for licensure of limited practitioners, and definitely upheld the former decision of various courts that the practice of Chiropractic is the practice of medicine. However, the Chiropractors did not give up their fight and periodically filed suit and introduced State legislation. It was not until 1949 that the Chiropractors obtained their own licensing mechanism in the form of Act 525, establishing the State Board of Chiropractic Examiners.)

Practitioner Found Guilty

PHILADELPHIA, JUNE 1929. On June 27, 1929, in Quarter Sessions Court, Philadelphia, Cyrus H. Raul, of 2237 Spring Garden Street, was found guilty of practicing medicine without a license by a jury which considered the evidence for less than three minutes. Judge Bouton, of McKean County, the trial judge, deferred sentence pending argument for a new trial, and Raul was released in \$2,000 bail. The penalty is six months in jail and a fine of \$500. Several former patients of Raul testified that he had supplied them with pills for a supposed heart ailment. Dr. Harrison, of the firm of La Wall and Harrison, chemists, testified that chemical analysis of some of these tablets showed them to contain strychnin.

This case was looked upon in Philadelphia as being in the nature of a test case, as the boast had been made that Raul could not be "gotten." Mr. Charles N. Fry, special investigator of the Board of Medical Education and Licensure, was the prosecutor. Raul denied that he had displayed a sign claiming to be "Dr. C. H. Raul," but the photograph shown on this page was conclusive evidence. He claimed that he was practicing on a diploma from the Naturopathic College, 1333 North Broad Street, Philadelphia, after having paid \$3,000 for his course. Newspaper statements, however, appeared to the effect that Thomas J. Goldberg, executive director of the Naturopathic



College and Hospital, denied that Raul had any connection with the institution. At this writing, decision has not yet been made on the application for a new trial, but it is not expected that this will be granted.

During the trial of the case, Mr. Fry received the following letter:

Mr. Fry—

They are going to get you if you don't get out of city.

A FRIEND.

Representatives of the Board of Medical Education and Licensure ask that physicians cooperate in such investigations as were made in the Raul case. In this way it will be possible to secure many more prosecutions. Physician informants will not be involved in the trial in any way.

Beware of So-Called Health Foods

WASHINGTON, D.C., AUGUST 1929. Beware of So-called "Health Foods"—The Food, Drug, and Insecticide Administration of the United States Department of Agriculture has released a warning that the American public should beware of "health foods,"

"life grains," and other food products for which makers claim curative or health-giving properties. The Administration believes the use of the word "health" in connection with foods constitutes a misbranding under the Food and Drugs Act. "The use of this word

implies," says W. G. Campbell, chief of the Administration, "that these products have health-giving or curative properties, when, in general, they merely possess some of the nutritive qualities to be expected in any wholesome food product . . . The label claims on these products are such that the consumer is led to believe our ordinary diet is sorely deficient in such vital substances as vitamins and minerals, and that these so-called 'health foods' are absolutely necessary to conserve life and health."

Of the "health foods" which have flooded the market in past years, there are generally three recognized classes. The first of these includes whole wheat, rye, oats, bran, and mixtures of these. "Valuable as these grain products are to the diet," says Mr. Campbell, "they are misrepresented when curative properties are claimed for them and when the maker says they provide 'life-giving vitamins in their tasty natural state.'"

Waters, mineral or mineral imitated, are sold by health resorts or promoters who attempt to convince the consumer that by their use at home the same benefits may be secured as by staying at the resort and following a proper diet and taking rest. Enthusiastic and glowing accounts of the merits of these waters are frequently exaggerations.

The third general group of so-called "life-giving" products includes candy containing calcium, salt containing iodine, food materials with phosphates added, bread containing carrot flour, crackers containing senna, a laxative drug, and chewing gum containing phenolphthalein, a coal-tar cathartic.

During the past few months the Administration has been giving attention to the merits of the newly introduced irradiated food products which, it is claimed, give the antirachitic vitamin D to the diet. Certain products when exposed to ultra violet rays, say the Food and Drug officials, become activated, developing antirachitic properties. But, they say, ordinary sunshine is rich in ultraviolet rays, and provides vitamin D in abundance. The use of a drugged food, therefore, is needless to persons getting plenty of sunshine, the Administration holds.

Board Proposes Remodeling

HARRISBURG, JANUARY 1934. The Board of Trustees of our Society at their December 11 meeting decided to proceed with proposed plans for much needed alterations and a fireproof addition to the Society's headquarters building at 230 State Street, Harrisburg, which will afford improved working facilities looking toward extension of the service of the Society to its members. When these improvements are completed, the building will

be not only in appearance in keeping with the dignity of our organization and the property's proximity to Pennsylvania's magnificent Capitol Building group and park, but will provide fireproof and waterproof facilities for the storing of archives, the development of library and of library package service, a museum, committee rooms, and a Board room capable of being converted into a meeting room to seat comfortably about 80 persons.



THE HEADQUARTERS BUILDING at 230 State Street after renovation: Indiana limestone decorated with ornamental carvings in carved stone and cast bronze symbolizing medical tradition.

National Health Conference Held

HARRISBURG, JULY 1938. The Federal Interdepartmental Committee to Co-ordinate Health and Welfare Activities held a National Health Conference July 18-20 in Washington, D.C., in order to find solutions to the health care problems of the nation.

The conference resulted in the committee's forming a five-point plan to be recommended to the next Congress.

Recommendation I involves the expansion of public health and maternal and child health services, estimated to cost \$200,000,000. Specific purposes would be: eradication of tuberculosis, venereal diseases, and malaria; control of mortality from pneumonia and cancer; mental hygiene; and industrial hygiene.

The second recommendation deals with expansion of hospital facilities. The committee recommends a 10 year program providing for the expansion of the nation's hospital facilities by the provision of 360,000 beds—in 5546 new general hospitals with 180,000 beds, and in new tuberculosis and mental hospitals, in rural and in urban areas—and by the construction of 500 health and diagnostic centers in areas inaccessible to hospitals. Special federal aid for this purpose is suggested; approximately half the total annual cost (construction, \$110,650,000; three-year maintenance, \$35,400,000) should be met by the federal government.

In the third recommendation the committee urges the provision, through grants in aid to the states, of medical care to those who are already part of the public assistance program, a work relief program, or a general relief program and to those who are able to obtain food, clothing, and shelter, but unable to procure necessary medical care. This part of the program may be begun with the expenditure of \$50,000,000 the first year and gradually expanded until it reaches an estimated level of \$400,000,000.

In its fourth recommendation the committee urges consideration of a comprehensive program designed to increase and improve medical services for the entire population. Such a pro-

gram would be directed toward closing the gaps in a health program of national scope left in the provisions of Recommendations I and III. To finance the program, two sources of funds could be drawn upon: (a) general taxation or special tax assessments, and (b) specific insurance contributions from the potential beneficiaries of an insurance system. The committee recommends consideration of both methods, recognizing that they may be used separately or in combination. No calculation of the costs of this part of the program is included.

The final recommendation states that a disability compensation pro-

gram is not necessarily part of a medical care program, but the cost of compensating for disability would be needlessly high if wage earners generally did not receive the medical care necessary to return them to work as soon as possible. Temporary disability insurance can perhaps be established along lines analogous to unemployment compensation; permanent disability (invalidity) insurance may be developed through the system of old-age insurance.

The proposals resulting from the conference will be the basis for presenting legislation to the next Congress.

AMA Calls Special Session

CHICAGO, SEPTEMBER 1938. For the third time in the history of the American Medical Association its Board of Trustees has called a special session of the House of Delegates, to be held September 16-17, 1938, in Chicago, for the purpose of considering the recommendations resulting from the National Health Conference.

The Medical Society of the State of Pennsylvania, entitled to eleven delegates, will be represented by the following, who served in the regular 1938 session at San Francisco: Drs. Francis F. Borzell, Walter F. Donaldson, J. Newton Hunsberger, George L. Laverty, Frank P. Lytle, Curtis C. Mechling, Samuel P. Mengel, Charles G. Strickland, Charles Falkowsky, Jr., Arthur C. Morgan, and Howard C. Frontz. Editor Frank C. Hammond has also been invited.

Dr. Donaldson is chairman of the General Committee of 25 to consider the National Health Conference report, Dr. Borzell on the subcommittee to study Recommendation II by the Technical Committee of the National Conference, and Dr. Mengel on Committee on Reports of Officers.

Delegates from the State Society were asked by the Board of Trustees and the Committee on Health Legislation to consider the following:

1. Creation of a federal Department

of Health, represented in the President's Cabinet by a Secretary of Health, authorized to coordinate all health activities which are now scattered throughout other federal departments.

2. Call another conference to reconsider the expansive measures now proposed and replace them with much less extravagant programs.

3. Request the A.M.A. to maintain representation in Washington to inform congressmen and senators of the medical profession's viewpoint.

4. Offer alternatives to the *overly expansive and expensive* proposals for the development of health programs.

In addition, the Board of Trustees requested that the following resolution of the Dauphin County Medical Society be conveyed to the A.M.A. House of Delegates:

WHEREAS, The Social Security Act of Congress made possible the creation of an Interdepartmental Committee to Co-ordinate Health and Welfare Activities, and

WHEREAS, The chairman of said Interdepartmental Committee convened a session known as the National Health and Welfare Conference, and

WHEREAS, Various proposals there discussed are economically extravagant, sociologically impracticable, scientifically stifling, and professionally deteriorating, and

WHEREAS, The President of these United States did publicly proclaim that a "co-ordinated national program of action" is imperative, be it

Resolved, That the Dauphin County Medical Society, through the duly constituted State Medical Society, does hereby petition the American Medical Association:

(a) To announce, publish, proclaim, and promulgate by commercial radio, press release, paid advertisement, and

public acclaim such specific methods and measures as its duly constituted officers and its House of Delegates recommend as practicable and expedient, within scientific and economic limits, in the prevention of illness and the conservation of the health of the citizens of the nation, and

(b) To combat, oppose, contradict, and amend, by the same means, such idealistic, fanciful, impracticable, and extravagant schemes as will rebound

eventually to encourage malingering, stifle initiative, retard progress, and disrupt the traditional physician-patient relationship. And be it further

Resolved, That the proper representatives of the American Medical Association be empowered also to accept voluntary contributions from individuals and organizations, lay and professional, who may choose to assist in underwriting the expense incident to this proposed effort.

Special Session Considers Recommendations

CHICAGO, SEPTEMBER 1938. The special session of the A.M.A. House of Delegates to consider the recommendations of the National Health Conference was held as scheduled.

The following pronouncements of the House of Delegates, designed to serve as guides for the charting of the future course of American medicine in our changing social order, are purposely broad, dealing largely with principles, basic and ethical, which, if adhered to and incorporated in any contemplated scheme of expansion, should permit of the preservation of those intangible things in the delivery of medical care for which organized medicine has so long contended and

which, in truth, mean far more to society than at first blush is realized.

The pronouncements, while brief, are clear, concise, statesmanlike, and shorn of all verbose redundancy; they should be *not only read but carefully studied by every physician who loves his profession.*

The House of Delegates approved the general outline of the first recommendation of the health conference, to expand public health, and maternal and child health services. The delegates also urged the formation of a federal Department of Health, as suggested by the State Society.

Delegates favored the second recommendation for expansion of general hospital facilities as needed but stressed that at present there is a greater need for the use of existing hospital facilities than for additional hospitals. The stability and efficiency of many existing church and voluntary hospitals could be assured by the payment to them of the costs of the necessary hospitalization of the medically indigent.

Support was given by the delegates to the third recommendation to provide medical care to the two broad groups of people unable to obtain medical care themselves. The committee believes that in each state a system should be developed to meet the recommendation of the National Health Conference in conformity with its suggestion that "The role of the federal government should be principally that of giving financial and technical aid to the states in their development of sound programs through procedures largely of their own choice."

The point where there is total di-

vergence of the view of organized medicine and the National Committee is in the fourth recommendation. The A.M.A. approved the principle of hospital insurance and recommended handling it as a community project. Delegates stated further that plans should be confined to provision of hospital facilities but should not include medical care. However, *the House of Delegates were not willing to foster any system of compulsory health insurance, as such a complicated, bureaucratic system "has no place in a democratic state.* It would undoubtedly set up a far-reaching tax system with great increase in the cost of government. That it would lend itself to political control and manipulation there is no doubt."

Finally, the A.M.A. delegates felt that for the guidance of the profession at large throughout the country there was real need for a definition of the phrase "medically needy" or "medically indigent." After much debate, this the House endeavored to do in the following language:

"A person is medically indigent when he is unable, in the place in which he resides, through his own resources, to provide himself and his dependents with proper medical, dental, nursing, hospital, pharmaceutical, and therapeutic appliance care without depriving himself or his dependents of necessary food, clothing, shelter, and similar necessities of life, as determined by the local authority charged with the duty of dispensing relief for the medically indigent."

Legislation is now being written to be introduced at the next session of the Congress.



WALTER F. DONALDSON, M.D., Society Secretary, served as chairman of the AMA General Committee to consider the National Health Conference Report.

House Passes Medical Service Bills

HARRISBURG, APRIL 1939. On April 26, 1939, the long-awaited legislation, authorized October 5, 1938, by the House of Delegates of The Medical Society of the State of Pennsylvania, passed the House of Representatives of the Pennsylvania Legislature. These bills, known as House Bill Numbers 686 and 685, make it possible for those with annual incomes up to \$2,500 to subscribe *voluntarily* for a complete insured medical service at a cost ranging from \$2 to \$2.50 per month. This voluntary insurance will be free from political domination and will be controlled with proper state supervision by definite representatives of those who will deliver the professional services.

Though this field of insurance is not unexplored, there are uncertainties which will have to be removed by experience.

We append a brief digest of House Bill Numbers 686 and 685, as prepared after many months of wise counsel with Director William C. Woodward of the A.M.A. Bureau of Legal Medicine and Legislation, with competent actuaries, and with well-known constitutional lawyers of the Keystone State.

Members of our Society should acquaint themselves with these bills, and should continue to keep in close touch with the legislative committees of their own county medical societies.

Brief Digest of (Pa.) H. B. 685 and H. B. 686 Providing for the Organization of Nonprofit Medical Service Corporations for Subscribers of Low Income

Introduced by Representatives Saraff, Hindman, and Serrill (all physicians). Referred to Committee on Public Health and Sanitation.

1. Two measures are proposed. One is a regulatory act and the other amends the Nonprofit Corporation Act of 1933 P. L. 289 to provide for the incorporation of nonprofit medical service corporations for subscribers of low income, that is, persons without dependents receiving incomes not in excess of \$30 per week and persons with one dependent not in excess of \$45 per week, and with more than one dependent not in excess of \$60 per week over a period of 6 months.

2. The corporations are voluntarily organized and controlled by physicians and may operate over a large or restricted area as their Articles of Incorporation provide.

3. Such corporations shall be subject to regulation by the Department of Health and the Insurance Department of the Commonwealth.

4. The application for a charter shall be submitted to the court of the county in which the corporation has its main office, but shall not be granted until the said 2 state departments have endorsed their approval thereon.

5. Medical services are defined as services generally rendered by licensed physicians of the Commonwealth.

6. All licensed physicians are permitted to be registered with such medical service corporations and furnish the medical services therein provided.

7. The terms of the contracts entered into with the subscribers and the fees paid the physicians, who will render such service, shall be approved by the said departments.

8. Relief officers of the state or political subdivisions may contract for the medical services provided for under the proposed act.

9. Persons who are required by law to maintain dependents, and are unable to provide the services at their own expense, may subscribe for the medical services herein.

10. Every nonprofit medical service corporation is declared to be a charitable and benevolent institution and exempt from all forms of taxation.

11. The annual charges for the medical service are to be paid in either lump sums or in installments.

12. Unauthorized nonprofit medical service corporations providing similar services are prohibited, unless they organize as provided in the proposed act.

13. The proposed act includes a declaratory provision that these services are a necessity because, under existing conditions and circumstances, persons of low income are unable to budget their finances to provide adequate medical care and services.

14. The regulatory measure contains a severability clause and provides that the act shall become effective immediately upon its final enactment.

Acts Signed, Incorporators Appointed

HARRISBURG, JUNE 1939. The bills, numbered 686 and 685, providing for the formation of a Medical Service Association, passed the Senate and were signed by the Governor; they are known as Act Numbers 398 and 399.

Additionally, the Insurance Commissioner of the State has approved the Society's proposals for the organization of the Medical Service Association, and the Dauphin County Court has granted the charter.

On June 15, 1939, the Board of Trustees of the Medical Society of the State of Pennsylvania authorized President David W. Thomas, M.D., to appoint the incorporators to proceed

with the formation of the Medical Service Association of Pennsylvania. The incorporators appointed by Dr. Thomas are the following: Lester H. Perry, Harrisburg; David W. Thomas, M.D., Lock Haven; Louis H. Clerf, M.D., Philadelphia; A. Alfred Waserman, Esq., Philadelphia; G. Harlan Wells, M.D., Philadelphia; Robert L. Anderson, M.D., Pittsburgh; Walter F. Donaldson, M.D., Pittsburgh; C. L. Palmer, M.D., Pittsburgh; and Robert V. White, M.D., Scranton.

A special session of the Society House of Delegates will be called to consider further organizational plans for the Medical Service Association.



DAVID W. THOMAS, M.D., Society President

Medical Service Association Organizes

HARRISBURG, APRIL 1940. A meeting of the members of the Medical Service Association of Pennsylvania was held on April 3, 1940, at 230 State Street, Harrisburg. The following members were in attendance: Louis H. Clerf, M.D., Walter F. Donaldson, M.D., Chauncey L. Palmer, M.D., Lester H. Perry, David W. Thomas, M.D., A. Alfred Wasserman, Esq., and G. Harlan Wells, M.D.; Robert L. Anderson, M.D., and Robert V. White, M.D., were absent on account of illness.

The important action at this meeting was the formal adoption of the amendments to the bylaws of the association suggested by action of the House of Delegates at its special meeting held February 28, 1940.

Immediately following the membership meeting, a meeting of the Board of Directors was held with the same group in attendance.

The following officers were elected: President, Chauncey L. Palmer, M.D., Pittsburgh; first vice president, Louis H. Clerf, M.D., Philadelphia; secretary, Lester H. Perry, Harrisburg; treasurer, Robert L. Anderson, M.D.,

Pittsburgh; executive committee—Walter F. Donaldson, M.D., Pittsburgh, David W. Thomas, M.D., Lock Haven, Dr. Palmer, and Mr. Perry.

It was decided that the 2 additional vice presidencies created at the suggestion of the House of Delegates not be filled until after the membership of the association had been increased to include representation from each councilor district. In that way the additional membership created on recommendation of the House of Delegates would be eligible for election to the additional offices also created on recommendation of the House of Delegates.

Educational Fund Established

PHILADELPHIA, OCTOBER 1948. Acting upon the proposal of Elmer Hess, M.D., in his presidential address of the 1947 session, the House of Delegates have established an Educational Fund in Article IX, Section 5 of the Society Constitution. The fund is to be

At the board meeting the modifications in the Participating Physician's Agreement and in the Subscription Agreement suggested by action of the House of Delegates were formally adopted.

The following 3 problems were referred to the Executive Committee: (1) The problem of alternative plans on the deductible or limited service principle; (2) the problem of the maximum benefits allowed in any one year; and (3) the wording of the section in the Participating Physician's Agreement to cover the \$3 assessment.

The Insurance Commissioner is expected to approve revisions in the near future.

"... used to assist in the underwriting of the expenses of continuing the education in high school, college, or medical school of the children of members of this Society if and when said training is about to be discontinued for lack of family financial support following the death, or incapacitating illness, or injury of the physician parent member of this Society."

Each year the Board of Trustees and Councilors may appropriate a sum, not to exceed \$2.00 for each active member, to be set aside for the fund. It is to be kept separate from other funds and may be invested by the Secretary-Treasurer as directed by the Board.

Chapter VII, Section 9 of the Bylaws states that a Committee on Educational Fund, consisting of the Secretary-Treasurer and three members to be selected by the Board will oversee the distribution of money from the fund. The committee must consult members of the component society of the county from which the request for aid is received in order to determine whether the financial aid is needed and whether the applicant qualifies for higher education.

In proposing the Educational Fund, Dr. Hess said, "... For years I have been interested in our Medical Benevolence Fund. ... I have seen its benefits in action; however, the fund is limited in its use to the relief of



The Board of Trustees, 1948

FRONT ROW: Walter F. Donaldson, Secretary-Treasurer, Editor; Gilson Colby Engel, President; Frank A. Lorenzo, Chairman; Park A. Deckard, Retiring Chairman; E. Roger Samuel, President-elect; Park Berkheimer, Assistant Secretary-Treasurer. **SECOND ROW:** Francis J. Conahan, Second District; Joseph S. Brown, Sixth District; Charles V. Hogan, Fourth District; Leard R. Altemus, Eleventh District; George S. Klump, Seventh District; Herman H. Walker, Eighth District. **BACK ROW:** James L. Whitehill, Tenth District; Hugh McCauley Miller, First District; James Z. Appel, Fifth District; Thomas R. Gagon, Twelfth District.

Society Holds Centennial Celebration

PHILADELPHIA, OCTOBER 1948. The Centennial Celebration Session of the House of Delegates of the Medical Society of the State of Pennsylvania convened in the Clover Room in the Bellevue-Stratford Hotel, Philadelphia, October 3-7, 1948. Only once in the one hundred years since the birth

of the State Society has the annual session been marked by such expansive and expensive plans and preparations as resulted in the unparalleled program of scientific and social events which was smoothly and successfully unrolled.

A total of 6228 members, stu-

dents, and guests were in attendance for the centenary celebration. The registered attendance was unusual and most gratifying and should thoroughly satisfy the state pride of the most enthusiastic supporter of Philadelphia as having one of the nation's great state medical associations.



PRESIDENT-elect E. Roger Samuel, left, Mt. Carmel, receives the congratulations of President Engel following his election by the House of Delegates.



AN OPERATION is performed before the television camera at University Hospital and shown to hundreds at Convention Hall, Philadelphia. The black wire running up the operator's back is connected to a microphone concealed in his mask so that he can describe the technique of the operation.

pecuniary distress. I want to see the Medical Society really do something more for its members or the members of their families. We are always doing something for others—let's now do something for our own.

"Most physicians marry comparatively late in life. Too often physicians die or are incapacitated while their children are in secondary school or college. Most of the families are not poverty-stricken or paupers, but the physician, if crippled, may not be able to have his most cherished possession, his children, continue with a higher education. Again, the widow and children of a deceased physician may live from his estate but without funds for the continuation of the children's education. . . ."



MRS. RUFUS M. BIERLY, president of the Auxiliary, presents one hundred roses to Past President Elmer Hess in honor of the Society's birthday, while Edgar S. Buyers, Chairman of the Advisory Committee to the Auxiliary, looks on.



THE INNOVATION of medical teaching to large groups by television was enthusiastically received. The result was "standing room only."

The Art and the Science

Physician filmmaker contributes to Bicentennial

DONALD FOX, M.D.

Philadelphia

The patient, a twenty year old white female, lay comatose, diaphoretic, obviously jaundiced and toxic.

The physician at the bedside notes her rapid, thready pulse, loss of skin turgor and stertorous respirations.

The physician's assistant, a young black, hands him a rectangular brass instrument. He grasps it firmly and cocks the trigger revealing nine razor-sharp blades protruding from the lower surface. With a quick positive thrust, he sinks the blades into the girl's anterior chest wall. A cry of pain erupts from the moribund girl as the blood wells up on her sternum.

The scene is suburbia, but not circa 1976.

The incident—a true vignette from one of the worst epidemics in



the history of American medicine, the yellow fever of 1793—provides the dramatic high point in the re-

cently released film, "The Art and the Science."

To produce a film in modern Philadelphia which would capture the mood and feeling of the late 18th century was not without trial and tribulation. Let me reflect on how it came to be.

Flowers drop upon the grave as the black skirted mourner passes in front of the camera to reveal a funeral procession in Christ Church graveyard.

The minister leading the group is an Italian Catholic who plays an English Episcopalian. To prove his versatility, the epistle he solemnly carries in his hand is a Hebrew prayerbook.

To the rear, the casket bearers strain under the weight of the heavy plain pine box. To be sure, no funeral director would offer so simple a casket to a bereaving family. Question: How did we come upon this basic box? Answer: With difficulty! Our search began



On these pages are scenes from the film, which dramatically illustrates the progress medicine has made, but details an event in the life of Benjamin Rush. Dr. Fox, who appears briefly early in the motion picture, is shown in the scene above.

with calls to the city morgue and wholesale suppliers of funeral equipment. After it became apparent that no such casket was commercially available, I ended up commissioning a patient of mine to custom-make our prop.

As the brief service in the graveyard concludes, a rich, earnest voice reciting Psalm 23 begins to rise on the sound track.

The scene now changes to the entire frame being filled by the black vestments of the Vicar of Christ Church and as the camera pans upward, it embraces the gold cross on his chest and finally his face fills the screen.

He implores his sparse congregation not to let fear overcome reason and to remain calm during the horrendous epidemic.

The camera now dollies down the aisle of Christ Church to reveal fifteen of my healthier patients in Colonial garb.

Aside from a camera dolly which broke, overloading the electrical system in Christ Church, and spending six hours to film twenty seconds of completed film, everything went smoothly.

Before we continue our story, let us introduce our characters. Our

Dr. Fox, a native Philadelphian who graduated from Hahnemann Medical College in 1954, has established himself as one of the outstanding independent film makers in the Delaware Valley. His film credits include the "Ali-Frazier Super Fights I and II" for theaters around the country; "Drive to the Hoop," a documentary of contemporary professional basketball, which was a silver medal winner in the New York Film Festival; and "Code 9," a spoof of modern medicine at a major urban medical center. Like an Alfred Hitchcock film, a Fox film invariably blends the talents of several family members. "The Art and the Science" is no exception since three children have bit acting roles; his wife, Kay, was responsible for the musical scoring; and his son in law, Jim Lipshutz, co-produced the film and was responsible for the still photographs which grace this article



star is Ben Rush, M.D., opinionated, liberal, and prohibitionist; the father of American Psychiatry and fifteen children of his own; signer of the Declaration of Independence; heavyweight blood-letting champion of Pennsylvania. Laboring under the work load of 80-100 acutely ill patients a day at a time when doctors saw patients at home, Ben wisely decided that he should employ a staff of paramedics.

Co-starring with Rush, is Absalom Jones, his trusted assistant. Jones had one big problem. He was

black! In Colonial Philadelphia where anybody who was somebody played the slaving game, a black physician's helper was as popular as smallpox. Despite his inborn handicap, Absalom went on to be ordained a minister in the Episcopal Church and ultimately founded one of the major segments of the Afro-American Church.

The femme fatale is Betsy Hiltzheimer, a rich merchant's daughter, who alternately groans and moans as the yellow fever surges through her system. Her big moment comes when her



pompous, wealthy father cries impassionately—"Betsy, Betsy, speak to me," and she replies in Academy Award fashion, "Yes, father."

Our supporting cast features Lenny the Leech—at the time the only live leech in captivity this side of London—who flew in from Rochester, N.Y., air-express, just in time to make a cameo appearance.

When first we meet Rush and Jones they are having a tete-a-tete in the vestibule of Pennsylvania Hospital. The goldhandled cane he holds is the same one which tapped the streets of Colonial Philadelphia in 1793. This, along with Rush's original scarifier, lancet, and bleeding equipment and medical box were generously loaned to us by the Mutter Museum of the College of Physicians. In fact, still within the box, were a box of Father Gill's pills and his BNDD license No. 0000001.

Rush reminds Jones to ready his leech jar for morning use and then steps out onto the steps on the south side of Pennsylvania Hospital. As he looks anxiously toward the river, his glance falls upon a horse-drawn hearse parked on the gravel path.

No, this was not an Avis-rent-a-hearse, but rather an original model, restored by the Philadelphia Carriage Company, which we

had fortuitously stumbled upon. The resultant footage of the scene looks as though it were torn from the frontispiece of an historical novel.

Jacob Hiltzheimer, the wealthy colonial merchant, is played by Mark McGovern. For the previous eight months Mark had cultivated a luxurious beard, only to be informed that he would have to be shorn for this part. To add insult to injury, when he dressed in his colonial finery, he had forgotten to wear shoes (he came attired in Adidas sneakers). Little did he know that Converse was the official shoe on the Main Line.

The filming at Appleford was punctuated by jet-liners flying over the house every five minutes, and a leaf-mulcher somewhere in the distance, which seemed to turn on in synchrony with our camera.

The sick bed sequences provided the dramatic highlight for the film, therefore no one will be seated during the last five minutes of the film.

As he and Jones drive away into the sunset, the prophetic words of Rush provide a fitting end to the film. "Yes, Absalom, the time will come when from the perfection of our science, pestilential diseases will cease to spread terror and death over the globe. The groans of pain, the ravings of madness and the sighs of melancholy shall be

heard no more. The cradle and the tomb shall no longer be related, for old age will then be universal. But long before this revolution in the health and happiness of manhood shall arrive, you and I must sleep with our fathers in the silent grave. But if we cannot share in the happiness we have destined for our posterity, we can contribute to produce it."

Paramount Studios with John Huston produced "Independence," The American Revolution Committee has come forward with "We Hold These Truths," and Public Television offers the "Adams Chronicles." Considering that "Independence" was budgeted at \$800,000; "We Hold These Truths" at \$300,000; and the "Chronicles" for \$5,000,000; it is indeed a modern miracle that "The Art and The Science" was initiated by a \$5,000 grant from the Pennsylvania Medical Society.

We hope the physicians of Pennsylvania and their families, along with all other physicians who visit our Commonwealth for the Bicentennial, will avail themselves of the opportunity to see our film.

From these primitive, humble beginnings of medicine depicted in our film, have developed the medical armamentarium as we know it today. Yesterdays "art" and today's "art and science" span the bicentennial of American medicine.



education

This issue carries no education course listings. The January issue contained a supplement—a comprehensive list of education courses being offered in all parts of Pennsylvania. Consult that issue or write for a copy of the supplement to: Council on Education and Science, Pennsylvania Medical Society, 20 Erford Road, Lemoyne, PA 17043.



Specials of the month

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Both for only **\$795**

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Message to Non Members

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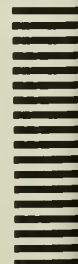
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***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.



Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential

status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

Pennsylvania Health Council Organizes

HARRISBURG, FEBRUARY 1950. On request of the American Medical Association and under the auspices of the State Society's Committee on Rural Medical Service, the Pennsylvania Health Council, Inc., was formally organized February 11, 1950, in the Old Caucus Room of The Capitol Building.

The Pennsylvania Health Council, Inc., is comprised of "... statewide organizations active in health fields, including official health agencies, voluntary health agencies, professional organizations, and others representing various groups of citizens with active concern in the health fields."

The Council's purposes are to coordinate the activities of all agencies concerned with health, to study health needs in the state, to develop and promote constructive health programs, to introduce needed health legislation, and to eliminate overlapping health programs.

A preliminary Council meeting was held September 20, 1949, during which Society Past President Gilson Colby Engel, M.D., of Philadelphia, was elected Acting Chairman. At the February meeting Dr. Engel was chosen as Council President.

Charter members of the Health Council include: the State Departments of Agriculture, Health, Public

Assistance, Public Instruction, and Welfare; Hahnemann Medical College; Jefferson Medical College; the University of Pennsylvania School of Medicine, the University of Pittsburgh School of Medicine and Graduate School of Public Health; the Woman's Medical College; the Pennsylvania State College; the American Cancer Society; the American Heart Association; the Hospital Association of Pennsylvania; the Pennsylvania

Osteopathic Association; the Pennsylvania Pharmaceutical Association; and the Pennsylvania Public Health Association.

Other officers elected by the Council are: C. Howard Witmer, M.D., Lancaster, First Vice President; Mrs. Philip S. Broughton, Pittsburgh, Second Vice President; William G. Mather, Ph.D. State College, Secretary; and Edward M. Green, Harrisburg, Treasurer.

Donaldson Retires, Gardner Elected

PHILADELPHIA, OCTOBER 1952. During the one hundred second Annual Session of the House of Delegates, Walter Foster Donaldson, M.D., retired after thirty-four years as Secretary-Treasurer of the Society. His successor is Harold B. Gardner, M.D., of Allegheny County.

Dr. Gardner is the fourth Permanent Secretary to serve the Society. The first was William B. Atkinson, M.D., who served from 1863 to 1897; next was Cyrus L. Stevens, M.D., who served until 1918 when Dr. Donaldson assumed the position.

The fifth annual State Dinner, held as part of the Annual Session, had Dr. Donaldson as the guest of honor. He received a gold wrist watch from the Society and a motion picture camera from the Auxiliary as tokens of ap-

preciation.

In honoring Dr. Donaldson, President Louis W. Jones, M.D., said, "Many of us, like a super nova, shine brilliantly for a short period and then disappear from view, but, like the sun itself, Walter Donaldson shines forever in his own light."

Although he has retired as Secretary-Treasurer, his ability and wise counsel are still available to the Society in his capacity as Editor of the PENNSYLVANIA MEDICAL JOURNAL, a position he has held since 1940.

Dr. Gardner was elected as the fourth Secretary-Treasurer on October 1, 1952. In nominating him for the office, W. Edward Chamberlain, M.D., of Philadelphia County, stated, "... Dr. Gardner, we all remember, was President of this Society 1950-51 and served his year as President-Elect prior to that. He has been a delegate to the American Medical Association for four years, has for ten years been a delegate to this State Society, and has served on very important committees, namely, the Committee on Public Health Legislation, the Committee on Medical Economics, and the Committee on Public Relations. He has held other offices. His whole career shows that he has never sought honors for himself; he has sought duties and opportunities to serve. He served his county medical society as President and on its board of directors for many years. I feel that the Society honors itself in offering to Dr. Gardner the post of Secretary-Treasurer."

He was elected and assumed the duties of the office that day.



GILSON COLBY ENGEL, M.D., elected President of the Pennsylvania Health Council, Inc., served as President of the Medical Society of the State of Pennsylvania in 1948.



HAROLD B. GARDNER, M.D., newly elected Secretary-Treasurer.

Dr. Gardner Moves to Harrisburg

HARRISBURG, JANUARY 1953. Effective the first of this month, the offices of the Secretary-Treasurer are located in the Society's Headquarters building at 230 State Street.

The closing of the Pittsburgh office, which since 1918 had been located at 1804 Jenkins Arcade, came simultaneously with the retirement of Walter Foster Donaldson, M.D., after thirty-four years as Secretary-Treasurer.

Dr. Gardner has recently moved from Pittsburgh to Harrisburg and has efficiently and quickly become a part of the organizational structure of the Society.

With the addition of the new offices in Harrisburg, the Society will need more space to operate efficiently, and will begin using the first floor of the building adjoining 230 State Street beginning in 1954.



THE PROPERTIES of the Medical Society of the State of Pennsylvania, located at 226 and 230 State Street.

Dr. Salk Develops Effective Vaccine

PITTSBURGH, APRIL 1955. A safe and effective vaccine against poliomyelitis has been developed by a research team headed by Jonas E. Salk, M.D., in the University of Pittsburgh Virus Research Laboratory. The announcement of the success of the vaccine is based on previous and effective inoculation of 1,500,000 American children.

Early in 1952 a polio vaccine had been developed in the Virus Research Laboratory which Dr. Salk was willing to try on a group of local children—previous victims of the paralytic type of polio virus. Results having been satisfactory, the research studies were extended to Allegheny County children (Dr. Salk's own three were first) who had not previously had polio.

Dr. Salk was officially cited for his work by the Governor of the State, the Mayor of Pittsburgh, and The Medical Society of the State of Pennsylvania. The latter citation took the form of the following telegram from President Dudley P. Walker:

"Your 12,000 fellow members of The Medical Society of the State of Pennsylvania, with a mingling of pride and

humility, gratefully accept this new and effective weapon against a disease which for centuries has caused such sorrow and tragedy to so many families."

Dr. Jonas E. Salk was graduated in medicine from City College of New York in 1939. On completing his internship he was married to Donna Lindsay, a graduate of Smith College and Columbia University School of Social Work. They had met as undergraduates while he was engaged in summer vacation research work at the Woods Run Marine Biological Laboratory, Woods Hole, Mass.

In 1942 Dr. Salk was awarded a fellowship in research by the Federal Research Council, then concerned with the development of influenza vaccine. He was assigned to the University of Michigan under Dr. Thomas Francis, Jr., who had been his professor in bacteriology at New York City College.

In 1948 Dr. Salk, then at the University of Pittsburgh School of Medicine, because of his progress in influenza research, was chosen by the National Foundation for Infantile Paralysis to determine the number of types of polio virus. Collaborating with

other scientists, the identity of three types of polio virus was confirmed and the search for an effective polio vaccine was definitely on.

(Editor's Note: Dr. Salk was the recipient in 1956 of the first Distinguished Service Award for his work on the vaccine for poliomyelitis.)



JONAS E. SALK, M.D.

Executive Director Appointed

HARRISBURG, OCTOBER 1956. Lester H. Perry, former Executive Secretary for the Society, has been chosen to serve as the first Executive Director. The appointment was made subsequent to changes in the Constitution and Bylaws proposed by the Board of Trustees and Councilors and approved by the House of Delegates in the last session.

Four years ago the Society elected a new Secretary-Treasurer, Harold B. Gardner, M.D. At the same time the Board of Trustees authorized the concentration of all the administrative functions of the Society in the Harrisburg office, necessitating the transfer of all the duties of the Pittsburgh office to Harrisburg and the establishment of the Secretary-Treasurer in residence in Harrisburg.

It was the opinion of the Board of Trustees at that time that the Secretary-Treasurer should be the administrative head of the Society and that the Executive Secretary should serve directly under him. The Executive Secretary should perform such duties as the Secretary-Treasurer might assign to him.

The newly elected Secretary-Treasurer was not too familiar with the work performed in the Harrisburg office. He requested a year to evaluate the organization and work of the Harrisburg office before making any plans of reorganization or outlining any job specifications. The request was granted.

During the past three years the Board of Trustees was aware that all had not been well in Harrisburg. Office administrative costs were going up, work output was not as good as previously, and more and more dissatisfaction was heard from members of the staff. In order to correct these deficiencies and prevent future mistakes in management, the Board of Trustees employed the firm of Rogers, Slade and Hill—Management Consultants—to study the present situation in Harrisburg and to make recommendations to correct the deficiencies.

Among the changes made in the organization of the Society are the following:

1. The administration of the affairs

of the Society is to be in the hands of a single individual who is well trained in the profession of administration. He is to be given full responsibility accompanied by complete authority in the administration of the Society.

2. The office of Treasurer of the Society is to be separated from that of Secretary and combined with that of the Executive Director.

3. The conventions of the Society, the meetings of the House of Delegates, the Board of Trustees, the committees and commissions, and all

other meetings of the Society should be the responsibility of the administrative officer of the Society.

4. The administrator is to fix the salaries and establish the terms of the employment of members of the Headquarters staff within general budgetary limits set by the Board of Trustees and Councilors.

For a complete report of the organizational changes approved by the House of Delegates, consult the September 1956 issue of THE PENNSYLVANIA MEDICAL JOURNAL.

Society Structure Changes

PHILADELPHIA, OCTOBER 1958. Due to the expanding concerns of organized medicine in the State, the House of Delegates at their one hundred eighth Annual Session voted to make substantial changes in the structure of the State Society. The Committee to Study Committees and Commissions began an evaluation of the Society structure in 1956, and after two years of activity submitted formal proposals to the Board of Trustees and Councilors who referred the report to the Committee on Constitution and Bylaws for publication of required changes.

According to Section 4 of Chapter VII of the revised Bylaws, all Society business must be carried on by commissions (except as provided for in other sections of the Bylaws) to be created by the House of Delegates.

Each commission or committee is assigned to one of four administrative councils: (1) the Council on Scientific Advancement, to extend medical knowledge and advance medical science; (2) the Council on Governmental Relations, to supervise and correlate activities which require liaison and cooperation between the Society and various government agencies; (3) the Council on Public Service, to supervise and correlate those activities of the Society designed to assist the general public with regard to problems of health and well-being; and (4) the Council on Medical Service, to study and make recommendations regard-

ing the social and economic problems which arise in the rendition of medical care.

Also created by the action of the House of Delegates is the Judicial Council in which judicial power of the Society is vested; the council's decisions are final but subject to appeal to the Judicial Council of the American Medical Association. The council has jurisdiction in all questions involving membership, the Constitution and Bylaws, or component county medical societies.

Commissions and the councils to which they are assigned, approved by the House of Delegates, are as follows:

1. Council on Scientific Advancement—Commissions on Blood Banks, Cancer, Cardiovascular and Metabolic Diseases, Chronic Diseases, Conservation of Hearing and Vision, Geriatrics, Physical Medicine and Rehabilitation, Maternal Welfare and Child Health, and Mental Health.

2. Council on Governmental Relations—Commissions on Federal Medical Service, Forensic Medicine, Legislation, and Public Health.

3. Council on Public Service—Commissions on Emergency Disaster Medical Service, Rural Health, Promotion of Medical Research, and Public Relations.

4. Council on Medical Service—Commissions on Blue Cross-Blue Shield, Distribution of Interns, Hospital Relations, and Medical Economics.

Coming on This Site—the New Headquarters Building

CAMP HILL, JANUARY 1965. This three and one-half acre tract in Camp Hill, just five minutes from downtown Harrisburg, will be the site of the State Society's new \$500,000 headquarters building. Schematic drawings of the proposed structure have been approved by the Board of Trustees and Councilors. Architects are working on interior designs. Construction is expected to start this spring, with completion scheduled for late this year or early 1966.

The proposed building, to house all Society offices, will be a three-story structure of contemporary design appropriate to the area. A Board meeting room, a small auditorium, and a modular arrangement of interior areas for flexibility in meeting Society needs, are among the special features. Most of the Society's council, commission,



and committee meetings now held at hotels will be scheduled in the new building.

The Society purchased this tract in 1961. Other major buildings in the area include the Blue Shield office building (visible in the background), a private school (on adjoining property),

the Penn Harris Motor Hotel (a near neighbor), and Camp Hill's Holy Spirit Hospital (about a half-mile away). The new building to be constructed here will replace the present Society headquarters in downtown Harrisburg, where space restrictions have been an increasing problem in recent years.

Ground Broken For New Building

CAMP HILL, AUGUST 1965. In a morning ceremony on August 5, ground was broken near Camp Hill, in Cumberland County, for the future Headquarters Building of the State Society.

Malcolm W. Miller, M.D., Chairman of the Building Committee, presided, presenting notable guests including Clarence J. McCullough, M.D., Chairman of the PMS Board of Trustees and Councilors, who spoke briefly, and Mr. Paul D. Acri, Vice

President of the East Pennsboro Township Board of Commissioners, who welcomed the Society in behalf of his area's officials and residents. The Rev. John A. Price, a PMS staff member, gave the invocation. Closing remarks were made by Wilbur E. Flannery, M.D., Immediate Past President.

Taking turns wielding the gilded shovel were Dr. Miller, Mr. Acri, Drs. McCullough and Flannery, and Mr. Lester H. Perry, Executive Director of

the Society.

Witnessing the ceremony were members of the Society's Board of Trustees and Councilors, members of the woman's auxiliary, the President of the Dauphin County Medical Society (Robert P. Dutlinger, M.D.), the President of the Cumberland County Medical Society (William L. Shelley, M.D.), and the PMS staff. Also present were representatives of the architectural and construction firms under contract for the new building.



MALCOLM W. MILLER, M.D., left, Chairman of the Building Committee, tosses the first shovelful of earth to the obvious delight of onlookers. Lester H. Perry, Executive Director, flings a huge chunk while Wilbur E. Flannery, M.D., Immediate Past President, follows a more conservative course.

State Has First Polio-free Year

HARRISBURG, JANUARY 1965. For the first time in the history of poliomyelitis in Pennsylvania, the state in 1964 had no known cases of the disease. According to Charles L. Wilbar, Jr., M.D., State Secretary of Health, this milestone record is due to the immunization programs so effec-

tively implemented throughout the Commonwealth.

In 1963, there were 110 cases—five times as many as in 1962—most of them occurring during outbreaks in Philadelphia and in the Cumberland-Perry-Franklin County area (almost one-fourth of the national

total for that year). Of these 110 cases, 89 were paralytic.

Nineteen other states also reported "No polio" for 1964, and the national total of 117 cases stands in dramatic contrast to the pre-Salk-and-Sabin incidence, in 1952, of 57,879 cases.

Medicine's Doors Open To Osteopaths

PHILADELPHIA, OCTOBER 1969. Fully licensed doctors of osteopathy in Pennsylvania may become members of the State Medical Society provided that they are accepted by county medical societies as the result of action of the 1969 PMS House of Delegates which approved changes to the Constitution and Bylaws.

The reference committee recommending the action to the House stated "that it paves the way for each county society to take whatever action it may desire with regard to admission of osteopathic physicians." The AMA took similar action in July.

The approved reference committee report noted that the State Board of Medical Education and Licensure had

acted to allow graduates of colleges of osteopathy to be admitted to rotating internships provided that they apply within five years of the date of graduation, and the Board action further noted that upon satisfactory completion of the rotating internship, they may apply for approved residency training in the various disciplines currently approved by the AMA.

However, the reference committee report said: "We recognize that many of the specialty examining boards do not admit osteopaths for examination. We are also cognizant of the many hurdles to be overcome before a truly meaningful relationship between the families of organized medicine and osteopathy can occur.

"We wish to emphasize the importance of continued effort by both parties to achieve the cooperation needed to produce the best possible medical care for our citizens."

The specific changes in the constitution and bylaws merely redefined the term "physician" to mean "a person holding an unrestricted license to practice medicine and surgery in the Commonwealth of Pennsylvania." Similar changes will be required in the constitution and bylaws of county medical societies before membership for osteopaths can be achieved and such changes and any subsequent membership action obviously is at the discretion of each county medical society.

Board Creates Flood Loan Fund

HARRISBURG, AUGUST 1972. As Pennsylvania moved into rebuilding large sections of the Commonwealth

out of the wreckage left in the wake of the flood of the summer of '72, the Pennsylvania Medical Society took a

series of steps to assist physicians and their patients in the areas affected.

The Board of Trustees and Councilors almost immediately established a \$300,000 Flood Damage Loan Fund, \$260,000 of which was distributed to applicants within three weeks of the flood, to aid Society members in reopening their offices as soon as possible.

The AMA Executive Council, responding to a call from the State Society, approved the allocation of an additional \$300,000 to back up the PMS loan fund. Use of AMA monies were coordinated through the State Society.

The State Society also established a special Flood Information Committee in cooperation with the Department of Health and other branches of state government. The committee approved and authorized publication of a bulletin on special health problems occur-



THE OFFICES OF Herman A. Fischer, Jr., M.D., Wilkes-Barre, typify the damage suffered during Pennsylvania's June floods. Dr. Fischer's office, above, and his examining room, on the opposite page, show evidence of the damage caused by high water and mud.

ing in the wake of the flood. The first of these bulletins was mailed to physician members in the following counties: Blair, Bradford, Carbon, Centre, Clearfield, Clinton, Columbia, and Cumberland, Dauphin, Huntingdon, Lackawanna, Lancaster, Lebanon, Luzerne, Lycoming, Mifflin-Juniata, Monroe, Montour, Northumberland, Perry, Schuylkill, Union, Wyoming and York.

To simplify and accelerate loan processing, members are directed to request a loan application from the county medical society. The completed application is to be returned to the county society, a committee of which will review the application and make recommendations, if any, to the State Society's Board of Trustees. Recipients of loans are being determined by a committee of the PMS Board on a priority basis, with both urgency of need to resume office practice as quickly as possible and financial need being considered. A check for the amount of the loan will be given directly to the member when he signs a note covering the loan. The note provides that the



money will be repaid in full, without interest, by June 30, 1977, at a minimum rate of \$105 per month beginning July 1, 1973.

State Society President George P. Rosemond, M.D., said in his memorandum to county society officers:

"These loans are intended to relieve the immediate financial burden on those members who suffered the greatest damage to their professional offices and they are not intended to replace federal loans or bank loans available to Society members."

Commonwealth Has New Medical Practice Act

HARRISBURG, JULY 1974. A journey which began in the summer of 1971 was successfully concluded on July 22 when Governor Milton J. Shapp signed House Bills 759 and 760 into Acts 189 and 190 providing physicians in the Commonwealth with a new Medical Practice Act.

Under the new act, physician membership on the State Board of Medical Education and Licensure remains the same. The five physicians currently serving on the board are: John W. Robertson, Jr., M.D., chairman (surgeon from Philadelphia); William J. Kelly, M.D., vice chairman (internist from Pittsburgh); Richard C. Lyons, M.D. (surgeon from Erie); Raymond C. Grandon, M.D. (internist from Harrisburg); and Philip E. Ingaglio, M.D. (general practitioner from Philadelphia). Two members of the state board also sit on the PMS Board of Trustees: Raymond C. Grandon, M.D., (Fifth District), and William J. Kelly, M.D., (Tenth District).

Added are a "public representative"

(consumer) and "a person who is knowledgeable in the field of allied health sciences."

The ex officio members remain the same: the secretary of health and the commissioner of professional and occupational affairs. This brings the total voting membership of the board to nine.

Despite sentiment in the House to move the health profession licensing boards to the Department of Health, the final Senate version keeps them in the Bureau of Professional and Occupational Affairs under the Department of State.

One troublesome issue was whether to require a medical school dean on the State Board of Medical Education and Licensure. The 1968 House of Delegates said yes. But testimony at the 1973 Annual Session ran against the proposal, and the policy was changed. The new law requires only that the five physicians be licensed and registered in Pennsylvania.

Licensing—The Board will issue four

broad types of licenses:

(1) Unlimited license to practice medicine and surgery.

(2) Temporary license valid for twelve consecutive months to participate in approved graduate medical training in an assigned hospital.

(3) Limited license which can be granted to foreign medical graduates who have attained "true status of teacher . . ."

(4) Midwifery, physical therapy, and drugless therapy.

Board Final Arbiter of Medical Education—Although rarely forced to use them, the state board has far-reaching powers over medical education in Pennsylvania. Not only may it set standards for acceptance to medical school, but it has authority over school curricula and training. The board also has power over hospital intern and residency programs and can, if the programs fail to meet board standards, refuse to license their graduates or permit students to enroll in their programs.

Biennial Registration Retained—The biennial registration with its fee and certificate of registration is retained. The two-part card sent out upon payment of the fee includes a portion designed as a wallet card. At the time of the gas strike these cards were used as identification to entitle physicians to emergency gas supplies.

Disciplinary Powers Strengthened—There are more details on conditions in which the board may "refuse, revoke or suspend" a license.

1. Failing to meet the licensing standards or violation of board rules.

2. "Making misleading, deceptive, untrue or fraudulent representations in the practice of medicine; practicing fraud or deceit in obtaining a license to practice medicine and surgery; or making a false or deceptive biennial registration with the Board."

3. "Being convicted of a felony in the courts of this Commonwealth or any other state, territory or country. Conviction as used in this paragraph shall include a finding or verdict of guilt, an admission of guilt, or a plea of

nolo contendere."

This language answers the question whether the state board can suspend or revoke licenses for conviction of income tax evasion or medicare fraud. Clearly the board can do so.

Board Required to Examine—While requiring the medical board to hold two examinations per year, the law closely regulates retakes. An applicant who fails has two years in which to take the examination a second time. Two-time losers must take a year of graduate study approved by the board before trying again.

The new act permits the medical board to accept in place of its own examination proof of having passed other exams such as the National Boards or the FLEX exam. FLEX stands for "Federation Licensure Examination," an exam sponsored by the Federation of State Licensing Boards. FLEX questions come from the pool of the National Board of Medical Examiners. Last December, Pennsylvania became the forty-sixth state to join the FLEX system.

Probation Power Added—Here are the disciplinary options open to the medical board under Act 190:

1. Deny the application for a license.

2. Administer a public or private reprimand.

3. Revoke, suspend, limit, or otherwise restrict a license.

4. Require licensee to submit to care, counseling, or treatment by a physician or physicians designated by the board.

5. Place a licensee on probation with the right to remove probation.

Due Process Guaranteed—While disciplinary powers are broad, all are subject to due process safeguards of the 1945 "Administrative Agency Law." They include the right of notice, hearing, and adjudication at which the accused has the right to counsel and cross examination. Finally there is the right of appeal.

Robert L. Lamb

Director of Communications

Pennsylvania Medical Schools Graduate 1005 in 1976

Jefferson Medical College

PHILADELPHIA, JUNE 1976. Jefferson Medical College, Thomas Jefferson University, held its 152nd commencement ceremonies June 11 at the Academy of Music in Philadelphia. This year's class of 217 new M.D.s raises the institution's total number of physician graduates since 1824 to 22,666, which is a national record.

Of the M.D. graduates, 34 received their degrees only five years after high school graduation; a cooperative program with Pennsylvania State University enables gifted students to complete their course of study through an accelerated program. Since 1968, 229 students have attained degrees in that way.

Honorary degrees were awarded to: Marian Anderson; James A. Michener; Jo Ono, M.D., a 1928 graduate of Jefferson Medical College and world renowned otolaryngologist; Roger Heyns, Ph.D., president of the American Council on Education; and Arthur Kaufmann, business and civic leader

and former president of Gimbel Brothers.

Graduate degrees awarded include: 12 doctor of philosophy degrees, 8 master of science degrees in clinical microbiology, and 2 other master of science degrees. Allied health degrees include: 21 bachelor of science degrees in medical technology, 58 B.S.s in nursing, and 2 associate of arts degrees.

Temple University

AMBLER, MAY 1976. The Ambler Campus of Temple University was the site of commencement exercises for Temple's School of Medicine May 27. Medical degrees conferred numbered 177, and degrees in health related fields totalled 160.

The ceremony was highlighted by the graduation of David Hartman, M.D., the first blind student in over 100 years to be accepted into a medical school.

Hershey Medical Center

HERSHEY, MAY 1976. John A. D.

Cooper, M.D., president of the Association of American Medical Colleges, was the featured speaker during the May 22 commencement exercises of The Pennsylvania State University College of Medicine, The Milton S. Hershey Medical Center.

During the ceremonies, held in Founders Hall of the Milton Hershey School, 77 M.D. degrees and 7 graduate degrees were conferred, including 4 M.S. degrees and 3 Ph.D. degrees (1 in physiology and 2 in pharmacology). The total alumni from the state's newest medical school includes 342 physicians and 62 scientists, who have received Ph.D.s or M.S.s in the basic medical sciences. One M.D. graduate became the third to complete the school's M.D.-Ph.D. degree program.

Medical College of Pennsylvania

PHILADELPHIA, MAY 1976. Graduation exercises of the Medical College of Pennsylvania were held May 29 in the Academy of Music, Philadelphia, during which a total of 86 medi-

cal degrees were conferred. Graduate degrees in medicine awarded included 2 master of science degrees in physiology, 1 M.S. in anatomy, and 1 Ph.D. degree in physiology (combined M.D.-Ph.D. program).

Mrs. Helvi Sipila, LL.B., assistant secretary-general for social development and humanitarian affairs for the United Nations, was the graduation speaker.

Four honorary degrees were awarded during the ceremony. Mrs. Sipila received a doctorate of humane letters. Mary Ellen Avery, M.D., who is Thomas Morgan Rotch Professor of Pediatrics at Harvard University, and Alma Dea Morani, M.D., clinical professor of plastic surgery at the Medical College, were awarded doctor of medical science degrees.

Jeanne D. Brugger, vice president of the Medical College's board of corporators, associate dean of the college of humanities and social sciences, and professor of psychology and education at Drexel University, received a doctor of laws degree. Mrs. Brugger is currently on a leave of absence from Drexel to serve as president of the Medical College during the search for a permanent president.

Hahnemann Medical College

PHILADELPHIA, JUNE 1976. Hahnemann Medical College and Hospital conferred 160 medical degrees and 148 degrees in allied health areas during graduation exercises held June 3 in the Academy of Music in Philadelphia.

Graduate degrees conferred included 5 Ph.D.s in the medical sciences, 7 doctorates in psychology, 32 master of science degrees, 21 degrees of master of creative arts in therapy, and 3 master of clinical microbiology degrees.

Honorary doctor of science degrees went to Howard W. Temin, Ph.D., American Cancer Society professor of viral oncology and cell biology at the University of Wisconsin, and E. Grey Dimond, M.D., provost for Health Science at the University of Missouri.

Honorary degrees of doctor of humane letters were awarded to Monsignor Wilfrid J. Nash, president of Gannon College, and William F. Hyland, attorney general of New Jersey.

Pennsylvania Medicine, July 1976



Former State Senator M. Harvey Taylor celebrated his 100th birthday June 4 of this Bicentennial year. He is shown above with David A. Smith, M.D., medical editor of PENNSYLVANIA MEDICINE, who is his personal physician.

University of Pittsburgh

PITTSBURGH, MAY 1976. Gerhard Werner, M.D., dean of the University of Pittsburgh School of Medicine, presented medical degrees to 133 students May 27 in Carnegie Music Hall. Edward C. Rosenell, M.D., executive vice president of the American College of Physicians and consultant to the U.S. Department of Health, Education, and Welfare, delivered the commencement address. Chosen for the 1975-76 Ace Internship was Edward N. Petersen, M.D.

Graduate degrees in the medical sciences conferred during the ceremony included 2 master of science degrees and 6 Ph.D. degrees. The School of Health Related Professions conferred 122 bachelor of science degrees and 20 master of science degrees.

Other degrees awarded during the ceremony were the following: from the Graduate School of Public Health, 61 M.S.s in hygiene, 111 M.S.s in public health, 6 Ph.D.s in hygiene, 5 Ph.D.s

in public health; from the School of Pharmacy, 97 B.S.s, 6 M.S.s, and 9 Ph.D.s; and from the School of Nursing, 161 B.S.s, 37 M.S.s, 5 Ph.D.s, and 39 M.S.s in nursing education.

University of Pennsylvania

PHILADELPHIA, MAY 1976. Irvine Auditorium was the site for the May 28 graduation exercises of the University of Pennsylvania School of Medicine. Medical degrees conferred totaled 155. The ceremony, which was held separately from the University's graduation, was highlighted by farewell remarks of Francis C. Wood, M.D., emeritus professor of medicine.

Degrees in allied health areas included: 30 bachelor of science degrees in occupational therapy, 53 bachelor of science degrees in physical therapy, 45 bachelor of science degrees in nursing, and 63 master of science degrees in nursing. This year's Nightingale Award in nursing went to William George Sciarillo, Jr.



A touch of medical history

Drugs and the treatment of disease have always attracted man's interest. Although we are all familiar with the notable occurrences and personalities that have contributed to the history of medicine in our country, there are many interesting facts and anecdotes that have been passed over. On our 200th Birthday, it seems appropriate that we should remember some of the sidelights of the practice of "physic" in America, the forgotten birthplace of medicine.

In colonial America, the clergy were often also the physicians, and barbers, surgeons. Colonial doctors must have been skilled in the culinary arts because many of the early cookbooks were written by them.¹ One of the reasons for these combinations was that it was difficult to earn a living by the practice of medicine alone in a country where the population was so scattered. Fees were small and often paid in trade items. Early colonial physicians received their training in Europe but with the birth of the first generation Americans the quality of medical care declined sharply. Because of the lack of medical training in the colonies, skill in and knowledge of medicine, surgery and pharmacy were at the lowest point in our history in 1690.

Giles Firmin of Massachusetts, one of the first clerical-physicians, read anatomy to students in New England as early as the 1640s.⁴ At a time when dissection was frowned upon and knowledge of pathology was largely nonexistent, one of the first recorded autopsies in the colonies confirmed that the patient had died of witchcraft.⁶

Colonial physicians produced most of their own medicines, many of which were borrowed from the Indian medicine-man.¹ John Pott, the first permanent resident physician of Virginia, was active during the epidemics, including yellow fever and plague, which swept through the early colonies. Doctor Pott was skilled in pharmacy and applied his knowledge in a rather unethical fashion on one occasion to poison a number of hostile Indians.⁶

Blood-letting and application of leeches were almost universally practiced. In 1793, Benjamin Rush used bleeding and hydrotherapy to treat the victims of yellow fever in Philadelphia and even applied this method of treatment to himself when he believed that he had contracted the disease.⁴ George Washington probably succumbed to an early death because of blood-letting secondary to laryngitis.⁶

A medical career was begun by an apprenticeship

during which the medical student doubled as a handyman and stable boy.³ Clinical instruction consisted of watching and assisting and lectures, of discussions between house calls.² After preliminary training, the student attended formal lectures at some medical school. These were only intended to supplement the instruction of private teachers. Upon completion of this course of training, the young physician was entitled to open a "shop."³

In time, a greater demand was placed upon medical schools. Professors were paid fees directly by students, rather than receiving a salary from the university. The professor then paid the university for the use of the medical hall.⁵ 1765 saw the establishment of the School of Medicine of the University of Pennsylvania, the first in the country. John Morgan was the first medical professor on the faculty. In 1768, ten students were graduated, receiving Bachelor of Medicine degrees. The degree of Doctor of Medicine was awarded after three years of professional experience plus a thesis in Latin. However, it was not until 1791 that graduates received Doctor of Medicine degrees instead of Bachelor of Medicine degrees.⁵

American medicine has made amazing progress since its humble beginning. We have developed, both scientifically and educationally, to produce some of the world's finest physicians. Students from other countries seek acceptance in our medical schools and postgraduate training programs. The medical care we offer is the best in the world. We physicians contributed to the vitality and strength of our country and have reason to be proud in this Bicentennial year.

David A. Smith, M.D.
Medical Editor

REFERENCES

1. Chitwood, Oliver Perry. *A History of Colonial America*. 3d ed. New York; Harper and Row, 1961, p. 473.
2. Clarke, Edward H., et al. *A Century of American Medicine 1776-1876*. New York; Burt Franklin, 1876, pp. 17-18.
3. Diller, Theodore. *Pioneer Medicine in Western Pennsylvania*. New York; Hoeber, 1927, pp. 53-54.
4. Garrison, Fielding H. *A History of Medicine*. 4th ed. Philadelphia; Saunders, 1929, p. 303, pp. 379-80.
5. Marion, John Francis. *Philadelphia Medica*. Harrisburg; Stackpole Books, 1975, pp. 96-97.
6. Wertenbaker, Thomas J. *The First Americans 1607-1690*. Chicago, Quadrangle Books, 1971, p. 165, 172, 175.

Science is insufficient

In the Ebers Papyrus, long predating the Christian era, the professional status and character of the physician were set forth. In these respects, he was the peer of other learned men—judges, astronomers, mathematicians, and priests. Usually his character was unimpeachable; he was a man of piety, who often administered remedies with a prayer. The Hippocratic Oath was written four centuries prior to the Christian era and its principles guided the physician in his ministrations to the infirm and sought to protect them against harm. Assuming that the physician was a religious man, the oath invoked the aid of the gods sacred to medicine. From the earliest period of recorded history, we learn that the physician was not accustomed to relying on his skill alone but sought help that could emerge from faith and religious beliefs in addition to his medical knowledge and capabilities.

With the advancement of scientific medicine, the physician is allowing a dispassionate impartiality, in some instances indifference, to vitiate his traditional, humanitarian, physician-patient relationship. In the fragmentation of medical science, too often the identity of the patient is lost; too often specialization demands that a different physician is required for every facet of the sick person's problem. In this impersonalization lie the seeds of loss of compassion and empathy for the infirm. It is shocking to hear a physician speak of the "hemorrhage in bed 10" or the "rectal cancer on Ward B." Such attitudes transform a sick person into a cipher and warm, friendly consultation into careless speech. Probably it signifies a shocking indifference to human values wherein resides the inherent dignity of the human being. Apparently humanitarianism is failing to keep pace with the advancement of medical science. Possibly it is this subtle deterioration of the traditional standards of professional decorum which is responsible for current loss of esteem for the physician by the public.

We are living in an age of codes precipitated by the utilization of electronic brains. Ever since biological life began, genes have been writing a code in deoxyribonucleic acid. Breaking the code would give us a better insight into the secrets of life. It would provide insight into the mysteries of many diseases. Now we know that viruses change the genetic codes of the cells they infect. Much study

has resulted in the discovery of the infectious properties of nucleic acid and the nucleoprotein structures of viruses. Literature on the nature of viruses and their relationship to nucleic acids and cancer is so abundant that the busy physician cannot possibly keep abreast of the literary output. One is forced to wonder if viruses change the genetic codes of the cells they infect. Will ways have to be devised to restore the original normal code of the cell? And if viruses cause cancer, will a new approach to therapy have to be evolved?

Undoubtedly, there is a tendency to devote too much attention to medical science and too little to the art of medicine. Recently, a California physician-priest was quoted as saying that when doctors make ward rounds among their elderly patients, it is merely a tour of watering the vegetables. Regardless of the age of the patient, loneliness is a sickness of the soul for which no panacea has been discovered, despite the advancement of medical science.

Long ago, Hippocrates wrote that: "Where there is love of man, there is also love of the art, for some patients, though conscious that their condition is perilous, recover their health simply through the contentment with the goodness of the physician."

The peculiar mystic characteristic of the humanitarian, ethical physician has a salutary effect upon the sick. There is much more in the healing art than administration of medication. The road of pain and physical disability are easier to travel if the physician gives abundantly of his goodness along with his medicine.

Another truth long known to the experienced physician is that the morale of the patient is an important factor in the battle for recovery. In the love of his art the physician can support the patient's morale immeasurably by a humane approach. More is required than superficial words of encouragement that fall lightly from the lips; such support must come from a deeper source. The sick should not be fooled. Goodness is not a gift; it is a quest. It is a garden which should be assiduously cultivated with sentiments that come from the heart to bring it to flower.

Joseph Conrad said: "What humanity needs is not the promise of scientific immortality but compassionate pity in this life and infinite mercy on the

Day of Judgment."

Death is a universal and inescapable experience, but it should be natural death that is a fact of nature, not death due to disease or violence. Death from disease should not be inevitable. With greater knowledge, it should be possible to eliminate incapacitating disease. Much has been accomplished in this respect, but continued research and the genius of dedicated investigators will achieve much more in the future. Already victims of coronary insufficiency live longer; tuberculosis can be cured and cancer patients survive beyond the 5, 10, and 15 year periods, and even longer. Perhaps the breakthrough will be discovered in the role of nucleic acids and viruses in cancer. We are forced to acknowledge that the battle appears to be unending. When one door is closed to death, another opens. "Death has ten thousand doors for men to take their exits," said John Webster, and, to Oliver Goldsmith, life was still "a damned long, dark, boggy, dirty, dangerous way." The physician cannot be callous about death, for death goes counter to the philosophy of one in whose ethos life and death are apposed.

In the early periods of the human race, there were gods of medicine and the dedicated man of medicine was not considered remiss when he invoked their help when treating the sick. Past centuries have witnessed many changes in the externals of religion. There have been changes as well in our time. In the lifetime of any person a half century old, changes in the concept of man have been seen. As human beings, we are considered to be biologically a mutable part of the whole fixed external center of the world. Like all biological forms, we tend to change, but what causes the change and for what purpose are questions that involve us with questions about a Supreme Being. No amount of scientific skepticism can entirely wipe out from our inner consciousness the fact that there is some real meaning in our existence and in the nature of the universe. This is what we know as religion. We cannot answer all the questions. They are written in a code for which, probably, the key will be found generations hence. Few medical men will fail, albeit silently but sincerely, to invoke the favor of some greater power when ministering to the sick. We no longer accept the stereotyped forms of earlier days, but to many the mystical experience of a Presence is not unknown. To the Quaker it is a common experience—what we call the "inner light"—a communion with and closeness to a Presence from which power may be drawn in time of need. Most of us pray, no matter what the form or the place, whether in church or at the wheel of a car or at the scrub-up basin, and we pray not always in movements of the lips nor with a folding of hands, but with the heart and with humil-

ity, for guidance and a sustaining faith.

Science alone is insufficient. Humanity, compassion, goodness, and empathy constitute "that best portion of a good man's life—his little nameless, unremembered acts of kindness. . . ." With faith and reliance on that inner light, the soul of medical practice can be restored. Let us not permit compassion and humanity to be brushed aside by the frenzied pace of our time.

Paucity of education in the humanities is seldom appreciated. Too often we become occupied by our professional activities to the exclusion of ordinary and everyday human refinement. Self-evaluation and self-improvements should always be an integral part of the plan of living of the physician. We should pause and reflect on the full meaning of the inscription on a temple of the Greeks, "Know thyself." If we have lessened our insight into ourselves, it is sure to be reflected in an equally diminished insight into the patient. The most supreme principles of human progress are the spirit of knowledge and the spirit of religion. If we can invoke them into our daily lives, we can best discharge our responsibilities to our patients.

A colleague and a close friend of mine has written: "The safest and most impregnable ground on which social advancement can be founded is the universality of affections. It is the bond of our common humanity; it is the golden link which joins together and preserves the human species. Affection can warm the coldest temperament and soften the hardest heart."

Generosity of spirit, discretion tested by a hundred secrets, tact tested by a thousand embarrassments, real affection, cheerfulness, and Herculean courage should be restored to the sickroom. If the cold, institutional atmosphere of the hospital can be replaced by touches of human kindness, if patients can be sick persons and not numbers, if a spirit of humanitarianism can prevail in all our professional activities, then the art of medicine will flourish, then it will be revealed that the physician who outwardly appears to be a man of the world performs duties that "often resemble those of the minister or the priest." His life is dedicated to the service of others. His influence will be required to equalize the struggle between scientific man and moral man. He will seek and he will find those spiritual values which nourish and glorify the soul of man. When he has accomplished this and added it to the fruits of scientific advancement, then and only then will his ministrations to the infirm be sufficient.

Harry E. Bacon
Contributing Editor
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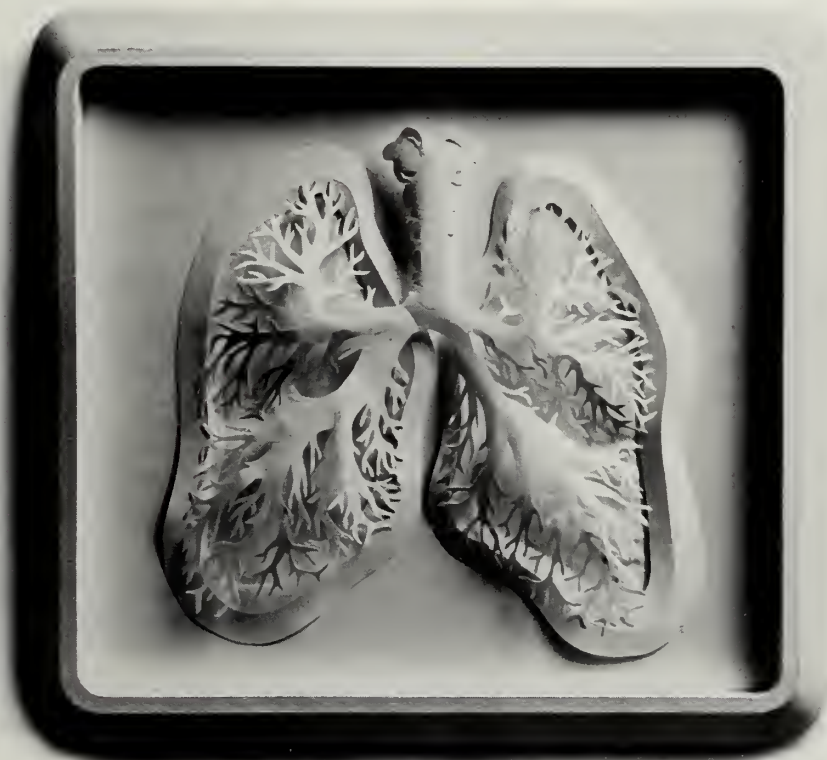
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Yesterday, today, and tomorrow

ROGER O. EGEBERG, M.D.

Washington, D.C.

Yesterday, today, and tomorrow can be taken literally to refer to 24-hour periods. Once you leave that definition, yesterday quickly becomes a generation, and if you are not careful, it can become a century.

The yesterday that I would like to start talking about was the yesterday when Dr. Donaldson was active; when individuals could broadly influence medicine; when Dr. Donaldson as a statesman in our field left his good imprint on the medicine of this whole state; when Sir William Osler had his great influence on the practice of medicine, the handling of patients, and the teaching of medicine; when John B. Murphy, William or Charlie Mayo, or Oschner single-handedly made tremendous impact on surgery, on institutions, on geographic areas, on the care of people.

Yesterday started in the 1890s and ended with the end of World War II. The horse and buggy doctor was the image of the earlier practitioner; sanitation and preventive medicine came in and changed our vital statistics dramatically; medicines were few, surgical procedures still relatively simple; psychiatry was still unborn; and the availability of medical care was haphazard and depended a lot upon geography. Doctors were loving individuals, we think, and their organizations were honored.

A number of significant occurrences make the change from yesterday to today: the advances that occurred in surgery in World War I; the results of the successful public health programs of sanitation and inoculations, and the beginning of some education in health; the increase in health expressed in the newspapers by the burgeoning columns of health advice; the opening up of new fields in medicine and in surgery; the extraction of insulin; the rather accidental discovery of sulfa drugs; the dis-



Dr. Egeberg presented this paper as the second annual Walter F. Donaldson Memorial Lecture at the 1976 Officers' Conference, held April 21 and 22 in Harrisburg. The annual lecture was established to honor the memory of Dr. Donaldson's more than fifty years of inspiration and leadership to the Society.

Dr. Egeberg is special assistant to the Secretary of Health, Education, and Welfare for health policy and special consultant to the president on health affairs. His varied and extensive career has included membership on the President's Advisory Cancer Council, and the Special Medical Advisory Group to the Veterans Administration, of which he was also chairman. Past teaching appointments include professor of medicine at the University of California at Los Angeles, the College of Medical Evangelists (now Loma Linda University School of Medicine), and the California School of Medicine, of which he also served as dean. In his present positions Dr. Egeberg is responsible for presenting the Administration's health initiatives to the health needs of the nation.

covery of the usefulness of liver in pernicious anemia; and then with Sir Arthur Fleming's discovery of penicillin, the rapid broadening of the field of surgery, the control of infections; the great advances in endocrinology and endocrine treatment, and the birth and rapid expansion of psychiatry. All of these and much more brought us to today.

I suppose today might be described as intermittent showers changing to sleet or snow with the possibility of a sudden rise in temperature and hurricane "medical."

It is certainly a day of great advances in medicine, of tremendous changes in social thinking, of great congressional interest, of consumer representative intrusion—for good or for bad—of continued respect and love for individual physicians, but deteriorating image of medicine as an institution.

The year 1917 is cited as a landmark. Patients seeing their physicians—and this would have to be physicians across the board—prior to 1917 had less chance of recovering, more chances of permanent sequelae to their illness, and on the whole they would have been sick longer than if they had stayed home and used Aunt Mary's gentler treatments.

Research and the advances in medicine accelerated—accelerated in a parabolic curve, and of course, with the advent and the use of antibiotics the opportunities and accomplishments of surgery multiplied greatly; and in medicine, changed the picture of lobar pneumonias that we so dreaded every winter. While they were the "old man's friend" and killed him off, they also killed many between the ages of 30 and 50.

Lobar pneumonia has been so well eliminated that younger doctors do not even know what red hepatization

and gray hepatization are or were, nor are they aware of the mystique of treating lobar pneumonia and the anxious awaiting of the crisis which usually came on the odd numbered days. I have always presumed that if it didn't occur on an odd numbered day that the doctor juggled the day of onset.

Advances in diagnosis and treatment have continued so that one can now say that medicine has advanced more since 1943 than it has in all the history of mankind up until 1943. Then with the recitation in the papers, magazines, later radio and television, of all of the wonders about medicine that could be accomplished, people sought help increasingly. The middle class and the well-to-do sought it from their own physicians; the poor, if they lived in a big city, from the city and county hospitals. But if they lived in small towns the poor had to depend on the charity and largess of individual physicians.

When President Eisenhower called his conference on aging—a White House conference held in 1960 towards the end of his administration—4,000 or 5,000 people drawn from many disciplines decided that the right to health care was the right of all Americans along with the right to food and shelter. This sounded good to our people and to Congress, which rushed to pass 50 bills in the 1960s—50 bills on health—some of which were good and broad and were thoughtfully worked out, such as medicare, and others of narrower scope aimed at individual diseases more selfishly proposed, or medicaid, whose purpose was to help the poor throughout the country.

For a decade, tapering off in about 1967, Congress greatly expanded

health research through the National Institutes of Health and with grants to the medical schools throughout the country. What Congress really voted was that approximately 20 million people who had had little or no health care should now have health care. They honored research and through research medical schools were able to beg, borrow, or steal time for teaching, but neither Congress nor the administration envisaged the impact on health care demands at all levels of society that the 20 million additional people would help to bring about, and they did virtually nothing about supporting teaching in medical schools or in worrying about distribution. They just assumed that if money was available for treatment, doctors, dentists, nurses, and hospitals would spring up to take advantage of that.

I know that this audience is aware of what happened. Many people flocked to take care of the poor and set up offices on the fringes of slums. Some good people were drawn in to help take care of the sick and to help them keep well. However, such a concentration of people suddenly able to pay bills drew charlatans, money grubbers, to the slums or to their edges. Some of these were M.D.s, some not. Some built small proprietary hospitals, many of which, in Los Angeles for instance, were called murder mills.

I know you are all deeply aware of and affected by the malpractice problem, and one needs to mention it at this point. While medicine is the hardest hit by such suits, architects, builders, engineers, and other professionals are very much affected.

Without going into the many causes of our malpractice crisis, I would mention one basic overall cause, and that is the rapidly increasing litigiousness of our society that exists. People increasingly want to blame others for anything untoward. A man stumbles on the pavement and instead of saying, "How could I be so stupid?" he looks carefully for a crack to see if he can't blame somebody else. This is a very threatening fracturing of society with a greatly increasing number of people involved in, or worried by, the large number of adversary situations. Aside from what this does to individual groups, it feeds

on itself and causes jealousy and resentment of any and all establishments. The American Bar at very high levels is at present deeply concerned with this problem.

The federal government has spent well over 100 billion dollars on health in the last decade—perhaps in the last five years. It is difficult to estimate what we have gotten for this money, or better, what the people have gotten for it. So far we can find no statistical evidence to show that it has affected longevity. We assume that it has given millions of people that good feeling that they have a physician who knows about their condition or their health, who can diagnose and care for them if they get sick, and give them moral support when they need it.

Now that is pretty vague, and Congress, a number of organizations, and our Department of Health, Education, and Welfare are wondering how one can document and justify the support of such expenditures with such unmeasurable results.

So today, with great advances in medicine, with great potential for helping people, with much information available to keep people well, with the medical schools turning out 50 to 60 percent more physicians than they did six years ago, with many millions of people getting health care who did not formerly get it, with the health care costs rising astronomically, and the doctors blamed for this, with the government asked more and more to intercede in medical problems, with Congress quite willing to do so, and with the many new laws and the veritable multitude of regulations evolving from them, we have a God damn mess.

Showers changing to sleet, possible snow, rivers rising, and a cattle killing drought in the west.

What of tomorrow? It takes an optimist to talk about tomorrow, and I am an optimist.

Tomorrow will bring increasing emphasis on keeping people well, through education, through training, and hopefully, through changing some of their habits. Aside from our own feelings of efficacy or wisdom, we wonder how long the taxpayers will tolerate our rising health budget, now 8 percent of the gross national product.



There will be drastic efforts at cutting down the cost. Since the greatest cost lies in hospitalization, this will certainly be tackled first. In the way of so many large federal organizations, it will probably start with ceilings which will soon, of necessity, get it into a degree of medicine by regulation or by committee. The practice of medicine will have to become more regulated as the government supports more, and regulations interpreting the laws multiply. There will be much greater use of those who extend the doctors' work—nurses, allied health professionals, technicians, and others. There will be a broadening of the insurance covering illness. It may go as far as universal comprehensive health insurance, or it may stop with catastrophic or narrower boundaries.

Will tomorrow be less chaotic? Will there be more of a feeling of cooperation between government and its aims and those who work in the health professions and have to deal with it? Will the balance go in favor of those who feel fiscal responsibility is important, or will it go to those who believe only social ideas are important, and there are many such.

I think that our new congress, which came to Washington full of good ideas they wanted to further, is becoming increasingly aware of the awesome cost of running our government. They would seem to be much more fiscally responsible now than the congress was before they came. For this reason, and because the administration, and particularly the Department of Health, Education and Welfare, would like it, I am sure we can expect an increasing degree of order to evolve from our present overlapping, duplicating, narrow, broad, and vague laws and regulations.

In the past doctors, probably because of their profession and their interest in patient care, have a tradition of not wanting to compromise. Because of this, we have lost many whole issues where compromises would certainly have been a much better solution. However, I think one sees increasingly among the leaders of medicine a realization that we shall have to compromise on certain issues, and thank goodness that we will

have to be beaten down to agree on others.

Our system of health care has been ridiculed and praised and its potential and results have been acclaimed and denigrated and now, as I mentioned earlier, with the federal government paying an increasing proportion of the health care, it will obviously want to be reassured that it is getting what it thinks it wants. This means regulations, so often written by young lawyers who want to be sure there is no misunderstanding, which in tone so often means they virtually want to do your job for you.

We are aware of this in Health, Education, and Welfare. Dr. Cooper is sensitive to the needs of the profession at large, and he has to be sensitive to the will of Congress and the orders from the Office of Management and Budget. The health planners working for Dr. Cooper, in cooperation with those working for Secretary Mathews, have laid out the framework for a more orderly progression of our health care system. Perhaps a unique aspect of this is that it is a living forward plan for health. By this I mean that their first plan has been circulated, not only through Congress where it has received a great deal of attention, but it has been sent to hundreds of groups outside of government to get their reactions and suggestions as to additions or deletions or changes they feel should be made. These changes have been discussed in the health areas of our department and many have been incorporated in the forward plan. This process will continue.

I cannot go into the details of the plan—it is a relatively thick bulletin, the first edition of which has been used up, but I would like to give you the problems that we hope to tackle and how we propose to approach them.

The problems, not necessarily in the order of importance, are: First, the economic ones, of which the greatest one at present is containment of the cost of health care. Second is a medical question with focusing on the issues of the quality and effectiveness of health care. Third is social and responds to the desires of our people with respect to the right to health care. This obviously begins with a

very important question and problem of access to health care. Fourth, it feels the need to look broadly and more completely at problems associated with health that are really not directly our problems or the doctors', such as the environment, gross and local, our social and economic conditions, and our behavior as humans. And fifth, it realizes the importance of more knowledge, more biologic knowledge about us and about our behavior, the need for research, and the need to study our health care institutions.

In responding to these five problem areas, the planning was organized around a number of themes. These are: prevention; development of knowledge; improving the health care system; assuring the quality of health care; response to whatever form of national health insurance is enacted into law; following of our problems and evaluation; and degree of success and improvement in management.

This is the first time that a broad suggestion of a plan for health has been prepared. The atmosphere in which it has been prepared is hopeful and looks to practical compromise. Congress is increasingly interested, and there is real hope for a workable solution to the delivery of health care in this country. Organized medicine will be vitally concerned and included in the further evolution of the plan. I am sure they will state their deep beliefs strongly and well, and I believe they have reached the point where they will be aware of the forces of society that have to be taken into consideration.

The future begins to look more orderly. More and more of the problem solving will come to you—to the states—where so much of it should be, and I wish you well with it. □



The medical profession and cultural change

JOHN C. BURNHAM, Ph.D.

Columbus, Ohio

In this bicentennial year many Americans are looking to their past. Such historical excursions can serve any number of purposes beyond the pleasure and reassurance of placing the present in a particular tradition. People use history particularly to gain perspective on present endeavors, but they also use it to project the past into the future.

Being an historian, I am comfortable only with times gone by and would not wish to take responsibility for making any projections into the future. Yet those projections come as unavoidable by-products of any attempt to provide some perspectives on the medical profession, as profession, through the medium of its history. Certainly Dr. Ingelfinger's editorial in the recent *New England Journal of Medicine* about "De-professionalizing the Profession" spells out the reasons for every physician to consider his future status and functioning as a professional. And that is the subject that I hope today to illumine a little with the historical record. I want to focus on the development of the medical profession and perhaps suggest some of the recurring problems of that select group. I shall try to avoid getting distracted by the fascinating subjects of technical and clinical development and instead focus on the identity of the physician and his relationship to the changing culture of the West in general, both before and after 1776. Indeed, it is necessary to go beyond the history of the United States, for the profession of physician existed long before the American nation.

The medical profession has in fact a unique social role. In every culture, in every time, someone in the society has undertaken to play the role of healer, from the all-round professional, the witch doctor, to the most modern specialist

in our own tribal setting. Another figure, too, is omnipresent among human kind—the patient. So natural does this role seem to us that we even anthropomorphize animals to say that they are sick, or speak of the pathology of plants. Between the two figures, healer and sufferer, therefore, is one of the most universal of human social relationships, and the social nature of the relationship inevitably draws the physician into the most general of historical forces and of social changes.

Illness, then, creates the social role of the healer or physician. But in early times, we infer from cultural studies, this role was confused with other professional roles, in the person of a witch doctor. He not only acted as healer but as lawyer and clergyman.

And this generalizing of the professional role was not entirely inappropriate. A very bright sociologist once observed that every professional person serves human society by working in the gray areas where uncertainty exists, where the client in effect does not possess clear guidelines with which to make his own decisions. The professional exists to advise and to smooth over doubts. If the gods as well as nature were involved in the etiology of disease, a general practitioner to handle both was what society needed. And in fact our earliest records show the general nature of efforts to counteract disease processes. The Ebers Papyrus includes a religious incantation for a burn but ends with practical, empirically tested, natural treatment:



Dr. Burnham is professor of history and lecturer in psychiatry at The Ohio State University. He has published a number of monographs, articles, and books, including Psychoanalysis and American Medicine, 1894-1918 (1967). In 1975 and again in 1976 he has been a leader of a National Endowment for the Humanities seminar in the humanities for medical practitioners. He holds a Ph.D. in history from Stanford University

and from 1958 to 1961 was post-doctoral fellow of the Foundations' Fund for Research in Psychiatry. In the photo above, Dr. Burnham is shown with David W. Clare, M.D., Tenth District trustee, at the Allegheny County Medical Society headquarters in Pittsburgh where Dr. Burnham delivered this paper as part of a bicentennial lecture series sponsored by the State Society.

" 'O thou son of god, Horus! There is Fire in the Land! Though there be water there or not now, the Water is in thy Mouth, the Nile is at thy Feet when thou comest to quench the Fire.'

"To be spoken over Milk-of-a-Woman-who-has-Borne-a-Son.

"Cake

"Ram's Hair

"Apply to the Burn."

For ever after these early times, the priestly element never left the identity of the physician, even in much later times, as I shall have occasion to remark again.

The figure of the physician was emerging even though religion and medicine were not fully separated. From Babylonia, perhaps 3000 B.C., we have a light gray alabaster seal-cylinder inscribed:

"O Edinmugi, Servant of the god Girra, who helps mothers in childbed, Ur-Lugaledina the physician is thy servant."

Despite the ambiguities, in Babylonia there was substantial recognition that the physician was practicing and was recognized as such. In the Code of Hammurabi, for example, the doctor had his fees set, and even the problem of malpractice was dealt with: "If a physician operate on a man for a severe wound with a bronze lancet and cause the man's death, or open an abscess (in the eye) . . . and destroy the man's eye, they shall cut off his fingers." In that society there was already a large measure of lay control of the practice of medicine.

It was in classical Greek civilization that the roles of physician and priest became pretty clearly separated. Both remained in the healing business. Greek patients customarily utilized either or both, without feeling any contradiction. But Greek physicians were distinctive because they attributed disease to natural causes and attempted cures by naturalistic means. Medicine therefore was based

ultimately on the rise of naturalism and science for which the Greeks are in any event remembered.

Greek physicians were recognized artisans. That is, they belonged to a social class of skilled workers (not what we would think of today as a higher, professional class). They often wandered from town to town, or were attached to patrician families. When exceptionally gifted, their incomes could be considerable. These practitioners of medicine developed a systematic body of knowledge, and schools sprang up, the most famous at Cos. The teachers developed a system of recognizing their trainees and in turn requiring of them certain standards of conduct. The most famous of these standards was embodied in the Oath of Hippocrates, in which perhaps the most striking aspect is the emphasis put on the relationship between teacher and pupil, which, as in any apprenticeship, is modeled on the relationship between father and son. Even to this day the teaching tradition in medicine is remarkable and should not be taken for granted. No medical student can walk into a hospital without being literally besieged by residents and staff who want to teach him what they can.

Greek medicine later was carried to Rome, but most practitioners there were low status artisans peddling their doctoring from door to door. Only a few rose to eminence. Galen, the most eminent, himself compared the Roman doctors with robbers and said that the only difference between the two was that the latter carried on their infamous practice in the hills and the former in the town. But the very fact that quackery flourished shows the importance of the role: the Romans wanted healers. Pliny noted that people believed "in anyone who gave himself out for a doctor even if the falsehood directly entailed the greatest danger." While there was no licensure of physicians in Roman times, yet certain laws and customs helped distinguish between the well trained and the quacks. Only qualified persons could join the public sanitary service, for example, or gain fees by lawsuit. One curious result of the informal training process was that many practitioners did not finish all of their work, and so they specialized in

just those parts of practice in which they had heard lectures. The first specialists gained, therefore, the reputation of being inadequate, quacks, or open fakers. Martial satirized the specialization by remarking that "Cascellius draws teeth out or restores them, Hyginus burns away eyelashings growing against the eye, Fannius cures a swollen uvula without cutting it, Eros removes marks burnt into the skin of slaves, and Hermes is the best doctor for hernia."

In Greek and Roman times, despite the corpus of knowledge, despite the apprentice training, and despite statements of ethical standards of behavior, medicine was not a profession. It was a trade. Moreover, the corpus of knowledge was available to anyone who was literate, and many such treated their slaves, if not their families, themselves. Celsus, the great medical writer, was a layman.

The real legacy of those Greek and Roman times, aside from naturalism, lay in the establishment of the medical ritual. In this non-religious ritual, the physician played the part of non-religious priest. The priestly role therefore continued to be essential to the functioning of the physician. And the ceremonies in which he was the central figure persisted for 2500 years. Let me outline the ceremonies. Once the two figures, doctor and patient, came together, there followed diagnosis, prognosis, prescription, and finally, bill.

Diagnosis and prognosis were and are part of the priestly function of the physician, reflecting his training and wisdom. At a later time, as we shall note, diagnosis came to be particularly important. The prescription is at least as venerable a part of the ritual. The 1550 B.C. Ebers Papyrus prescription for burns accompanied by an incantation to Horus, I have already mentioned. By classical times the gods were left out, at least by the physician, and his own authority and his knowledge of nature gave potency to the prescription. No more was needed for snake bite, said Dioscorides in the first century, A.D., but powdered, dried testes of the hippopotamus, taken with water. From practice of that period to the use of sugar pills in the last century and a half, the prescription has been essen-



tial in the ritual practice of medicine, and the physician who sees patients without prescribing will lose his practice.

Likewise the doctor's bill has been a constant part of the ritual. Some of you will know the traditional children's song about the doctor in which advantage is taken of the fact that "bill" rhymes with "pill." The bill has also been a continuing source of bitter comment or humor, from the ancients down to our own day. Seneca observed that "People pay the doctor for his trouble; for his kindness they still remain in his debt." In the nineteenth century the country bumpkin patient was told by the physician that only his robust constitution had saved him, and of course the convalescing rube drawled, "I hope you remember that when you make out your bill, doc." The physician was in fact a standard figure in the famous Joe Miller joke books, in part on account of his propensity to bury his mistakes, but mostly because of his high fees and the desire of patients to avoid paying them, just as in Roman times.

This stereotyped medical ritual of diagnosis, prognosis, prescription, and bill seems likely to persist even though it is involved chiefly in the priestly functioning of the physician and in the personal doctor-patient relationship. Modern medical technology has re-emphasized the priestly role, and no amount of organization, specialization, and hardware seems able to reduce the importance of the doctor-patient relationship, as the recent increase in malpractice suits suggests. But after ancient times three forces have changed the role of the physician: first, professionalization; second, the impact of science; and third, the development of mass society and the accompanying bureaucratic style of organization.

After the fall of the Roman empire, medical teaching was kept alive, like other learning, in the monasteries, primarily. There the most adept students of medicine practiced, at least part of the time, but their practice was limited to the monastery, for the most part. In many places some medical lore was included as a part of a standard education, but the education was traditional and designed basi-

cally to produce clerics. Empirical practitioners and especially herbalists fulfilled the social role of physician, along with barber-surgeons. The very highest social groups occasionally utilized Jewish or other doctors who had access to Arabic or Byzantine learning, but Christendom was not a culture then that fostered professional physicians. "When one is ill," observed a thirteenth century critic, "let him not seek the physician; avoid his paths, be careful lest he visit you; . . . He comes with haughtiness and arrogance in order to increase the trouble . . . He gathers medical books . . . to make a show of them, but not to read them . . . He is the Reaper's agent; he is the assistant of the Angel of Death."

granting a monopoly of practice;

4. Ethical codes, with judgment enforced by peers, for the purpose of keeping the profession innocuous to society;

5. Functioning within a subculture, usually represented by professional associations;

6. Maintaining a neutral stance toward clients, that is, ambiguously non-profit and humanitarian, entailing moral obligations on the part of the client as well as the professional and with the fee system of payment separate from actual work;

7. Considering the profession a terminal occupation, a total and fulfilling calling, not a way station to some other destiny in a mobile society.

'Professional physicians developed with the rise of the universities in the thirteenth and fourteenth centuries on the basis of the tightly controlled society that characterized medieval civilization. The university degree became in effect a license to practice . . .'

Professional physicians developed with the rise of the universities in the thirteenth and fourteenth centuries on the basis of the tightly controlled society that characterized medieval civilization. The university degree became in effect a license to practice, and lay authorities enforced licensure. In turn, physicians formed a prestigious guild in European society (they did not work with their hands) and enforced their own standards among their own. From that time to the present physicians have attempted to maintain the status of a profession, the major hallmarks of which might be identified in this terms:

1. Possession and transmission of systematic theory and a body of knowledge on the basis of which the profession functions;

2. Authority, for the product sold is expert opinion, and the customer is not always right;

3. Community sanction, very frequently in the form of licensing and

Once established into the guild system, the physicians had a distinctive costume and a quite high social station. They were consulted for their learning, and they scrupulously refrained from using their hands. They were, therefore, quite distinct from members of the barber-surgeons' guild and the apothecaries' guild, whom they often employed as paramedical personnel. So the profession maintained itself right into the Enlightenment period of the seventeenth and eighteenth centuries. At that time the physicians tried to increase their authority further by associating themselves with the reason and science that marked the age of Newton, which soon became the age of the American Revolution.

Against this background, events in America can be put into better perspective. The medical profession that got itself involved in the War for American Independence was already by 1776 pursuing a course different

from that profession in Europe. Yet the priestly role and the medical ritual maintained itself intact. What had changed was the role of the profession in society, and from the point of view of many physicians, American independence was a disaster for the status of the profession. Partly the problem was the unsettled and open nature of American society, even before independence. But partly the problem was a general one and lay in changes in all of the Western world during the seventeenth and eighteenth centuries.

In the New World there were in fact hardly any university trained physicians, even after the founding of the first medical school at the University of Pennsylvania in 1765. In Boston at the time of the great inoculation controversy, only Dr. Douglass from Edinburgh had a degree. All of the rest were apprentice trained, usually already by the 1720s from the offices of local practitioners. As a result, the guild distinctions of Europe simply were never invoked. In America, a doctor was a general practitioner, rather as they existed in rural England. He played the role of physician, surgeon, and apothecary, filling his own prescriptions, which constituted often the most important part of his income. When John Morgan returned from Britain to found the first medical school, he tried to avoid selling prescriptions, but he could not change the pattern that was by then already established in the colonies. For a century physicians were expected to handle all cases that came to them, and even such eminent nineteenth century surgeons as Samuel Gross felt obliged to take cases in general medicine as well as surgery.

In the newly independent United States the absence of guilds underlined and intensified the general crisis of medicine at the end of the eighteenth century. With increasing

use of vernacular languages rather than Latin for medical writings, and with increasing literacy of the population (and of course especially in the United States), the monopoly on medical knowledge was broken. In America, Benjamin Franklin's Poor Richard could observe that any person who reached the age of forty was either "a fool or a physician." Students in college often took a course in medicine as part of a liberal education. Quacks who could read or write just a little flourished, and one of the benefits of democracy was the ability to read for one's self the advertisements of patent medicine vendors and then to dose one's self without the costly intervention of a physician (very much as a Quaker might do without a priest). The extreme was reached perhaps in the 1830s with Samuel Thomson, who included with the sale of each book a certificate that the purchaser was entitled to practice Thomson's botanic system of medicine on himself and his family, and further certifying the owner as a member of the botanical medical practitioners' professional society.

Yet medicine was gaining slightly in effectiveness. At the end of the eighteenth century vaccination was discovered by Jenner, with results that really were impressive. Moreover, as the specificity of disease came to be more and more accepted, the ancient practice of quarantine came again into vogue, especially as transportation improved and people moved about a great deal. The one man to whom the community could turn for diagnosis was the physician. Here the expert really could command impressive professional standing. He might bleed people to death, but he could still help isolate cases of communicable disease.

By the beginning of the nineteenth century, despite the slight improvements in the practice of medicine, the physician still depended upon tradition and a blind faith in a very dubious theoretical science. Yet even the tiny increment in the effectiveness of medicine was creating a new situation. For the physician it was not good. Medical practitioners gained a great deal of self confidence, and they redoubled their efforts not at diagnosis and prevention so much as

therapeutics. They abandoned the Hippocratic healing power of nature and prescribed furiously, competitively, and bled in the same way. This was the age of heroic medicine—and the heroes were of course the patients. And after a while a negative reaction set in. The doctor became the object of social anger. In only one area was society able to proceed very effectively against this priestly caste, and ironically this was in the area where some real scientific progress was being made, anatomy and pathology. You are all aware of the adventures of medical students of a former day who had to procure their own cadavers from the local graveyard, and how this culminated often in mob action. The most notorious case, in which murders were committed to provide a Scottish medical professor with class material, stuck in the mind of the public.

But even all of this might have been forgiven if the doctors were curing. But they were not. The early nineteenth century, then, represented the low point, for centuries, in the physician's prestige. Being a time of economic liberalism, the mood, particularly in England and America, was to let anyone try to cure who wished, and let the buyer beware. Obviously the most successful of the competitors would survive—and those who were unsuccessful would kill off their customers. The situation was not very different from that of Roman times, including the pretentiousness of the physicians and the valiant attempts of the better men to improve the situation. In fact, the less one prescribed the more likely his patients were to survive (this was the secret of the so-called homeopaths whose success so infuriated the regular physicians). But what was the alternative? To say that a physician could diagnose, do some public health work, and then just comfort the patient?

By 1850 free enterprise was practiced to such an extent that in virtually all of the states any restrictive licensing of physicians was repealed, and the myriad of medical sects—allopath, homeopath, eclectic, botanic, and others not so reputable—battled with each other for the public's patronage. Attempts



of the American Medical Association and other reform groups to establish standards even among "regular" M.D.s were wrecked by threatened sectarians and by the avariciousness of medical teachers who made money by turning out as many students as possible from the proprietary medical schools.

It is difficult to exaggerate how low the medical profession of the United States sank in that first century of American independence. Quacks and patent medicine vendors multiplied. The most respectable people denounced the doctors. A Philadelphia editor despaired of medical students, saying that they were crude, coarse, and ignorant, and that they were consequently despised by the better people of the city. After an inadequate education, he continued, they went forth to contribute to the "poisoning and surgical butchery [which] have already been committed in thousands of instances." The physicians who themselves really did have good training often seemed to be more interested in getting the better of their competitors such as the homeopaths than in upgrading either medical practice or medical education. In fact massive bleeding, dosing with calomel, and other practices threatened to kill off the patients who loyally stuck by regular physicians. Even that area in which medicine was effective, vaccination and quarantine, came under heavy attack from the general public from time to time.

One might well ask how medicine got itself out of this state of disorganization and venality. The story is largely one of the continuing development of medical science and technology. Early in the nineteenth century medical statistics was introduced from France, and slowly the empirics gave way before clinical medicine. The technical innovations in surgery changed the whole argument about effectiveness of medicine even further. Knowledge of public health, even before the germ theory of disease, moved that important endeavor further and further from the realm of public prayer to the realm of sewage and water supply, especially after the terrifying cholera epidemics of the nineteenth century. And finally medical science came in, especially

from Germany. With pathology and physiology came essential understanding of what a disease was, and with the germ theory of disease came certain knowledge of the cause of infectious illnesses.

I have mentioned the impact of science and of the bureaucratic organization of society upon the professional condition of medicine. These two factors began their operations at the same time, the late nineteenth century, and remained the dominant factors throughout American medicine in the second century of national independence. It is hard sometimes

late nineteenth and early twentieth centuries. A new robe—the white lab coat—came to be distinctive professional dress.

But the science of that period was largely negative. The rise of bacteriology and pathology meant that competent medical personnel could now label quacks quacks and make the label stick, setting the stage for the rise of effective licensing laws which, again, were largely negative in character, excluding people from the practice of medicine. Yet the scientific, licensed physician was not much more effective than Hippocrates had

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to separate science and social organization. Specialization, for example, the most obvious development, was a product of both the explosion of knowledge and the increasing interdependence of people in our society.

Scientific innovations did affect the condition and social circumstances of the medical profession most profoundly. In the first place, it was the regular doctors, rather than the hydropaths or homeopaths or botanics, who had stood for research, which meant adding to and increasing the body of knowledge that marked professional identity. And of course the growth of knowledge soon removed medicine from an area of learning available to just anyone. Once again it became the exclusive domain of a highly educated elite. Moreover, the physicians, as in the eighteenth century, added to their stature by placing medicine under the mantle of science, which was becoming more and more prestigious and further and further removed from the layman in the

been. Only quinine (cinchona bark) and then rabies and diphtheria antitoxins and, later, salvarsan had been added to the traditional therapeutics of known effectiveness. It is true, the priestly functions of diagnosis and prognosis were now greatly enhanced. Also the ceremony of prescribing continued, but no one knew better than the well educated M.D. just how ceremonial it was. As late as 1932, for example, a couple of pediatricians could complain that "The tendency in medicine today is to devote more attention to the cause and prevention of pathologic states than to the therapeutic or other measures devoted to their amelioration or cure."

Especially after the development of antiseptic and aseptic techniques, there was one very bright spot in medicine—surgery. The technical developments, in which Americans came increasingly to share, while interesting in themselves, were very important to the medical profession,

especially in the United States, where surgery was still united with medicine, despite the beginnings of specialism. Beginning about 1890 American medicine entered the age of surgery proper. As surgeons worked first on the abdomen and then the thorax and brain, real miracles occurred, and the public image of the lifesaver in operating regalia made a very great impact indeed. The ever more literate public were fed on the results of such medical practice, even as that same public understood less and less exactly how the procedures were carried out. The newspapers exploited the excitement and drama of the special trains carrying Dr. Mayo of Rochester or Dr. Crile of Cleveland to perform some life saving operation. But the technical details now were the concern only of the M.D.s or, at most, the state licensing boards. The physician who worked with his hands, the surgeon, for the first time became more prestigious than the long-robed, learned brain worker, thus reversing the traditional hierarchy.

But the new science brought effectiveness of medical practice in one more area, besides surgery. That was the area of prevention, mostly in the field of public health. The public became vividly aware of such facts as the assertion by a 1908 writer that "The Ohio River represents a thousand miles of typhoid fever." The accomplishments of public health campaigns in the United States within the last century are well known. But in fact both public and profession moved with caution, for the whole medical professional functioning now took on a new aspect, that of social functioning. No longer was the physician always confronting his patients as individuals, nor was the use of physicians necessarily a personal matter for each American. Collective medicine took both healer and suf-

ferer far from familiar guideposts for behavior and judgment.

As early as 1916 David L. Edsall of Harvard Medical School was discussing freely how what he called "the relations of the profession to the public at large" had been altered in basic ways by scientific innovation: "... these developments have made medicine a much more complex profession, and have added a new and very important character to the calling. It is not simply that the details of progress have made it necessary to acquire more varied and extensive scientific knowledge in order to practise medicine. It is also and even more largely because, far more than was ever true before, they have imposed upon physicians the need of looking upon their profession in its relation to many general economic and social problems of the community as a whole, quite as much as in its relations to the individual sick. . . . The doctor has always been somewhat cloistered from the world of affairs. . . . Medicine has, in fact, attracted very largely men who temperamentally shun public activities. Besides this, one of the more or less definitely recognized large compensations in medicine, and one that has been most jealously guarded and perpetuated, is that the doctor owes obedience only to the law and to his own conscience, and is not subject to human masters. As a consequence, he has often avoided and even resented, anything that interfered with his freedom of action, and this, together with the fact that there were few positions of dignity open to medical men in which they were parts of a system or were subordinate to higher authority, has made the general idea of being part of a machine moving in necessary co-ordination with other parts, usually distasteful. . . . But the developments of recent decades have shown beyond peradventure that the broadest and most beneficent activities of medical men in preventing and eradicating disease have in later times been, and will mostly continue to be, not brilliant individual researches or individual struggles with disease, but organized systems of attack in which everyone, whether in senior or junior positions, will be no longer a free lance, but subordinate

to the system, and dependent upon it for his success."

As alert observers of those times such as Edsall recognized, the changes in science were having profound effects on medicine in the direction of integrating it into an interdependent society. And so it was that bureaucratic types of organization and activities came into medicine throughout the second century of independence, by means of circumstances within the profession as well as in the surrounding culture. As soon as physiology and bacteriology permitted the quacks to be labeled, as we have noted, the profession organized and introduced, with lay concurrence, regulation and restrictive licensing of medical practice. Even before the Flexner Report of 1910, the American Medical Association had begun to get all medical education brought up to standard, and by the 1920s the entire country was under regulations so strict and uniform that the system was becoming unwieldy and had to have some flexibility in the curriculum introduced by committee fiat. Charitable and preventive work, too, was organized, and often centralized, either in governmental or in private, but still bureaucratic, organizations. All of this was natural, apparently desirable, and entirely parallel with other developments in American society, although it must be observed that of the many elements in that society the medical profession was most resistant to integration into bureaucratic modes of organization.

The effectiveness of medical treatment had consequences that changed the bureaucratic position of the profession in most profound ways. One was the complete transformation of the hospital and the development of an essentially new institution with the gravest portent for the future of the profession. In the nineteenth century the hospital was a charity institution. Society provided for the unfortunates. There philanthropic people could direct their altruism to the most needy—the most memorable example no doubt being one lamented nursing sister in a Boston children's hospital who devoted herself to doing good for pauper youngsters even as she herself was dying of consumption, coughing



through the wards. In general the hospital was a place where the unfortunate went to die; the better classes stayed home to be ill, where the family physician could attend them.

At about the turn of the century the hospital suddenly came to be a place to get well, an institution from which was reflected the new image of miracle working medicine. The Mayo brothers, whom I quite deliberately mentioned above, came to symbolize the new American dream—medical care as good as any in the world, right in the neighborhood, in every community in America. For surely if so unlikely a town as Rochester, Minnesota, could have that care, any community in the country could. Such was the aspiration that built thousands of hospitals and staffed them with physicians and paramedicals who were charged with fulfilling an important part of the dream. But it was a couple of generations after the brothers Mayo before the full potentials of the hospital as medical institution dawned on most people.

Meantime, well meaning bureaucratically minded people, including most of the medical school and hospital oriented members of the profession, were struggling to bring medical care to the public in a systematic way. And for the public, the delivery of medical care was for the first time of very substantially more than ceremonial importance. Medical care had become a truly public issue, genuinely of social concern. It was at this point, and for that reason, that the subject of medical insurance came up, just before World War I. In 1917 the American Medical Association House of Delegates almost committed the Association to compulsory medical insurance (on the state level, of course), noting that blind opposition to what they called the "rising tide of social development" would "leave the profession in a position of helplessness." Those were, as it turned out much later, prophetic words.

Many advocates of insurance schemes had in mind the European systems that had been established to provide benefits for wages lost through sickness. Indeed, the famous 1917 proposal included burial costs as part of medical insurance. But the

forward looking leaders in medicine recognized that medical practice was inefficient. What they proposed to do was to reorganize medicine in the United States in connection with changing the traditional fee system. Usually what they had in mind was a sort of HMO, because both group work and prevention, they knew, were far more efficient and would go further than the type of private practice that predominated then. As two health administrators wrote in 1918, "The efficiency idea applied to dispensary services comes to full fruition in organizations formed for the coordinated practice of medicine on a scientific but business basis. The Mayo Clinic . . . is simply a large Dispensary. . . . It was established and is maintained for the efficient practice of medicine."

'At about the turn of the century the hospital suddenly came to be a place to get well, an institution from which was reflected the new image of miracle working medicine. . . .'

It was in the face of this threat that the majority of private, general practitioners revolted, responding to their own feelings as well as to insurance company charges that public insurance schemes were pro-German and Bolshevistic. They got control of the AMA and, with Morris Fishbein as their spokesman, took a rigid stand against insurance in general and group or compulsory insurance in particular. They joined with such unlikely allies as the private insurance businesses, the A.F. of L., drug store owners, and Christian Scientists to paralyze almost all attempts, private and governmental alike, to change the basis of health care payment, or, incidentally, to effect any reorganization of practice.

The physicians' opposition deserves some understanding. It was not merely the result of propaganda. First there was the irony that practitioners who had performed priestly

roles in the early twentieth century found themselves suddenly able to perform miracles—and in their own offices. Naturally they were unwilling to admit that their work was inadequate. Fiction is filled with plots concerning priests and magicians who suddenly really can command the supernatural. American physicians had this happen to them in reality, not fiction, and their reactions were not unlike those in the stories.

Moreover, there was a perfectly sound reason for opposition to insurance plans. Already before World War I many M.D.s had had firsthand experience with private health insurance companies. That experience with third party payment had constituted a bad experience, for the doctors were often urged to give inexpensive treatment even though professional

judgment dictated more costly procedures.

The total result was ironical again. The physician organizations concentrated so much on the bugaboo of socialized medicine that in trying to do the right thing the American Medical Association and constituent societies lost the confidence of large parts of the public and finally of the profession itself. During the 1930s the spokesmen for the profession came to act as and appear to be merely lobbyists for a selfish interest group, that is, a mere business, akin to the trade associations that were so successful in that same period in influencing government policy and at the same time receiving praise for speaking for self-interest. Indeed, by 1944 the Supreme Court held against medical societies who were, as the court and the law put it, "in restraint of trade or commerce."

What had happened was that the



energy that had previously been utilized to expose quacks who bilked and harmed the public now was devoted almost singlemindedly to fighting socialized medicine. The efforts of the profession to upgrade practice through the formation of specialization boards was little known and appreciated. This increase in organization and bureaucracy was, as you all know, of the greatest importance. Instead, most Americans saw an often disgraceful propaganda campaign. *Fortune*, the magazine of business, in 1944 noted that representations of organized medicine were "often obviously mendacious."

Advocates of the sliding scale of fees could not disguise a more primary interest in the opportunity to make money, especially after the Great Depression of the 1930s had seriously diminished most physicians' incomes. An observer of the profession at the depths of the depression noted that the "psychology of the medical man has been adjusted to a speculative hope of exceptional success, a factor wholly absent in most other liberal and scientific professions, and one which frequently has an injurious effect upon the entire profession and the attitude of the average physician to social problems." This image of avaricious and not entirely truthful physicians was the legacy of yesterday's profession to the bulk of those practicing in the United States today. While the personal physician was usually excluded from the image, most M.D.s have nevertheless seen in their professional lifetimes a continual softening of medical opposition to third party payment schemes.

Within current practitioners' experience, then, the forces of science and bureaucratic organization have operated powerfully and in defiance of lobbyists and much else in the profession. The increasing use of labora-

tory and technical procedures moved the practice of medicine inexorably out of the private office and into the hospital. There the physician no longer owned his own tools but came under what the sociologists call the discipline of work, a constraint familiar to most physicians of the 1970s. More and more the practitioner became himself a manager, concerned with paperwork and personnel supervision. More and more medical education became so formidable that to be competent many physicians felt that they had to specialize, consult, and organize into groups. All of this led to increasing the impediments between doctor and patient and to changes in the doctor's role that led Dr. Ingelfinger to talk about deprofessionalizing in all its aspects, from being superseded by technical paramedicals to having practice directed by lay persons, either in the increasingly controlling hospital, or in some outside auditor's or lawyer's office. Or possibly, it now appears, in some advertising agency.

Under these circumstances both physicians and other Americans can well take the trouble to consider what the meaning and future of the profession as a profession may be. That there will always be healers, we can be sure from both history and anthropology. But whether physicians can maintain their own subculture and keep public respect is not so certain. As the cliché of the day puts it, medicine has become too important to be left to the physicians. And yet leaving it to the physicians is exactly what professionalism means. The customer is not always right. Instead, he has to honor the priestly authority. In medieval times, respecting and honoring people was an essential. Can a profession survive in a society in which respect and honor are no longer viable? Can lore and knowledge alone suffice to gain community sanction for a special professional status? As late as the eighteenth century aristocratic army officers in Austria could have the regimental surgeon flogged if his practice was unsatisfactory. Indeed, the knowledge and skill of the physician are still at issue, just as they were in the times of Hammurabi. Surely today many physicians must be wishing that the

heavily financed publicity agents of the American Medical Association during the past two generations had been preaching the inadequacies and uncertainties of medicine rather than the sufficiency—which was understood to be omnipotence—of the family physician.

Recent events justify physicians in being concerned about their profession and their professional status. It is no doubt cold comfort to talk about a professional as gladly serving whom he can when in fact we all live in a society in which money payments measure the social opinion of a person's value to society. Yet from ancient times it was not only the fee for service that marked the physician but both knowledge and the priestly function. In both there is much personal satisfaction. Mostly what is in jeopardy, then, is the relationship of the profession to the rest of society. Although cultural change will continue, and the place of the medical profession will continue to change along with the culture, at least the healing function is unlikely to be abolished.

As recent studies have shown, technical expertise is more vulnerable to lay interference than is priestly authority. Most seers have the same concerns as Dr. Ingelfinger and foresee increasing encroachments upon the profession as the scientific basis of practice increases. Technicians without medical training but privy to parts of medicine, for example, will, like the Roman specialists, increasingly compete with M.D.s. But I would point out that the history of the profession, as profession, is by no means so unambiguous. Transformation of the physicians' subculture, for example, could combine with cultural changes to produce some surprises, particularly in the realm of priestly functioning as represented just recently in the growing stress on the behavioral sciences in the medical school curriculum. A scenario for M.D.s in the third century of American independence as plausible as deprofessionalization might be the expansion of medical responsibilities until they embrace something closer to the all-round professional functioning of the witch doctor with which medicine apparently began. □

Tribute to Pennsylvania's earliest physicians

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While the Commonwealth of Pennsylvania serves as the focus for the nation's Bicentennial for preeminently political reasons, those among the medical profession can recall with pride Pennsylvania's contributions to the state of medicine in 1776. Not without reason has Pennsylvania been called the birthplace of American Medicine. Certainly here the practice of medicine began on a significant scale earlier than in any of the other original colonies.

Colonial medicine in Pennsylvania is a story of firsts. Here in 1765, in the midst of a feud, the first medical school of the colonies was born. Prior to the founding of this school, physician training was an irregular process at best. Some physicians were home-grown. Of one such example, William Shippen, Sr., we read: "The elder William Shippen, whose shop was at the Sign of Paracelsus' Head, was one of these [apothecaries]; as his experience and skill increased, his patients became more numerous, and giving up the trade of drug-seller, he rose to the rank of physician."

Many other early Pennsylvania physicians followed another typical training pattern. Deprived of opportunity for a formal medical education, they acquired their skills by the side of an established physician. This apprentice-preceptor method of medical education was the accepted

means of learning the skills of medicine.

The first preceptor of note in Philadelphia, which was long the hub of Pennsylvania's growing medical professionalism, was Dr. John Kearsley, Sr. Having received his medical education in England, he first came to Philadelphia in 1711. There he trained many students by the apprentice system, among them John Redman. For his contributions to the advancement of medicine, Dr. Kearsley has been remembered as "the founder of the medical profession in Philadelphia." In his pupil, John Redman, he forged a link to other early giants in Pennsylvania medicine. Redman, in turn, educated John Morgan, Benjamin Rush, and Caspar Wistar.

A few young Pennsylvanians could afford to journey to England for additional training. Many England-bound young men received the money and advice of a long-time friend of medicine—Benjamin Franklin, who was for a time America's representative in Great Britain. Franklin invariably sent these aspiring physicians to the great Quaker physician, Dr. John Fothergill. In London, a student could attend private lectures and walk the wards at St. Thomas' Hospital. "Post-graduate" education might include a trip to Edinburgh, as Fothergill frequently recommended, for study with famed scholars such as William Cullen or Alexander Monro. Some American students even travelled to the Continent, such as John Morgan who went to Paris to study with anatomist Jean-Joseph Sue, or Adam Kuhn who studied with Linnaeus in Upsala.

During one such English sojourn, two young Americans—John Morgan and William Shippen, Jr.—spent a month together in London and decried the backward state of their native country's medical education. Together they dreamed of establishing America's first medical school, then went their separate ways in the fall of

1761.

William Shippen, Jr., son of William Shippen elder, returned to America the following year. His father had destined him for medical greatness and trained him accordingly. On his return home, the younger Shippen undertook a much-praised series of lectures in anatomy. As teaching aids, he used a set of eighteen anatomical drawings by Jan van Rymsdyck. The drawings, along with a skeleton and plaster casts of the gravid uterus, had been entrusted to Shippen by Dr. John Fothergill who had presented them as gifts to the Pennsylvania Hospital for use in medical teaching. In conjunction with his lectures, Shippen also proposed the founding of a medical school, with encouragement in his plans from Fothergill. When his "friend and fellow citizen" Dr. John Morgan returned, they would teach together: Shippen in anatomy, Morgan in physiology.

Meanwhile John Morgan completed his European education and returned to Philadelphia. Before the trustees of the College of Philadelphia, he delivered his "Discourse Upon the Institution of Medical Schools in America." Unanimously adopting the plan, the trustees honored Morgan by naming him America's first medical professor—of theory and practice of medicine. Shippen had not been aware of the developments. Furthermore he was not consulted; thus began the feud that would continue over thirty years. Even though Shippen was awarded the school's chair of anatomy and surgery, becoming its second professor, he never forgave Morgan for stealing the prime honors.

The faculty of the new school grew with the addition of Benjamin Rush and Adam Kuhn. Rush taught chemistry and Kuhn botany and materia medica: together with Shippen and Morgan they comprised "the youngest faculty that ever sat in professors' chairs." In 1768, the first class of ten graduated with Bachelor



JOHN MORGAN

of Medicine degrees. By 1791, all graduates received M.D. degrees. Prior to that date, a doctor of medicine was granted to a student only following three years of medical experience and successful defense of his thesis written in Latin.

The college continued to grow and flourish through the early years. In the 1780s trouble erupted for a brief period when the rival University of the State of Pennsylvania established its own medical school. A decade later, reason prevailed and the two schools made amends. In the calm, they merged as the University of Pennsylvania, thus becoming the first institution in the United States to assume the title of university. Finally in 1824, a second medical college was founded to challenge successfully the University of Pennsylvania's monopoly on medical education.

A graduate of the medical school of the University of Pennsylvania, Dr. George B. McClellan (father of the Civil War general) delivered lectures at Jefferson College, in Canonsburg, Pennsylvania. Then in 1824, he transferred his lectures to a Philadelphia site close to the present campus of the school. From these beginnings, Philadelphia's second oldest medical college—Jefferson—emerged at a time when neither Paris nor London had two medical schools. The new school drew criticism from the University of Pennsylvania. In the mid 1800s students directly paid tuition to professors holding chairs at the medical school. Certain that Philadelphia could not support two medical schools, a faculty deputation from the medical school of the University of Pennsylvania travelled to Harrisburg to lobby with the Legislature. They argued that Dr. McClellan's school had no authority to grant medical degrees. Time proved wrong their analysis of student numbers. Within twenty years, Jefferson's enrollment passed the University of Pennsylvania's. During the nineteenth century, the two schools of medicine educated one in every four doctors in the United States.

Additional medical schools were founded in quick succession. Not all survived. Of those that did, few have stories as unusual as Hahnemann (1848) and the Medical College of

Pennsylvania (1850). Based in homeopathy, the school that was to become the Hahnemann Medical College opened in 1848 as the Homeopathic Medical College. Following a merger with another small medical college, the institution changed its name to Hahnemann Medical College in 1867. Named for Samuel Hahnemann, an early advocate of homeopathy, the school taught homeopathy as a supplement to traditional medical studies. The foundation of homeopathy was a firm belief in the body's natural curative powers. Medical intervention should be simple, stimulating the body to heal itself. Gradually, as scientific knowledge grew, homeopathy was phased out. The last doctor of homeopathy degree was granted in 1950; the last required course in homeopathy was dropped in 1945, with the last elective course in 1959.

In 1850, yet another medical school was founded in Philadelphia. Up to this time, any woman seeking a medical education had to fall back on the apprentice system, studying medicine under the aegis of some willing doctor. No medical school admitted women. Through the vision of William J. Mullen, not a doctor himself, who believed "women needed not grudging admission to co-educational colleges but a medical school of their own," the Female Medical College of Pennsylvania was born. Forty women attended the first lectures. The male medical community did not enthusiastically welcome this new venture. In fact, at the first graduation in 1851, so great was the protest of Philadelphia's male establishment that police reserves stood by to restrain the crowd and maintain order.

A whole series of firsts in medicine are tied to this college, which changed its name in 1867 to the Woman's Medical College and again, in 1970, to the Medical College of Pennsylvania. Not only was it the first woman's medical school in the United States, but in Ann Preston, M.D., it had the first woman dean. In 1867 Rebecca Cole became the first black woman to graduate from the college, the second to do so in the United States. Graduates of the college continued to pioneer in medicine, such as Dr. Emeline Cleveland who pursued

surgical studies in Paris for no place in America admitted women in surgery. Dr. Cleveland went on to become the first woman to perform an ovariectomy. In 1969, the college admitted men for the first time, precipitating the 1970 name change. In the years 1850, when the Female Medical College of Pennsylvania began, and 1895, eighteen more women's medical schools began. By 1910, only one survived—today's Medical College of Pennsylvania.

The focus of medical education had been, until the late 1800s, Philadelphia. In 1886, the Western Pennsylvania Medical College opened its doors to students, thereby establishing in Pittsburgh a medical school. Its first class graduated in 1887 with twenty-one students, including one woman making it a true co-educational medical institution. Eventually with the buying of the school's stock in 1908, the Western University of Pennsylvania became the University of Pittsburgh. Curiously, the medical school, which had allowed women to attend since its founding, reversed its policy for three years. From 1909 to 1911, the dean closed the school to women. Through the efforts of three eminent Pittsburgh physicians, the decision was eventually rescinded: they were Drs. Amelia Dranga, Margaret Gould, and Fannie Davis. Their work restored the school of medicine of the University of Pittsburgh to its place as a pioneer in co-educational medical training in Pennsylvania. A statement accompanied the reopening of the school to women: "The field for the woman physician in the city of Pittsburgh is particularly important, as this is a manufacturing center—and her work . . . is necessary. . . . The work of the woman physician has its place in the social welfare betterment of today."

The two remaining schools in Pennsylvania awarding M.D. degrees began more than a half century apart, both in this century. In the spring of 1901, an evening medical school opened at Temple College, the first of its kind in the United States. When Temple became accredited as a university in 1907, the school of medicine became a subscribing college. Finally, in 1918 the night school was disbanded. The newest medical school



PENNSYLVANIA HOSPITAL

in Pennsylvania is The Pennsylvania State University College of Medicine, The Milton S. Hershey Medical Center, begun in 1967. Hershey pioneered in educational concepts by becoming the first medical school to include social scientists on its faculty.

Not only was Pennsylvania first in establishing a medical school in the colonies but also in founding a hospital, the first in the nation in the modern sense of the term. Founded in 1751, Pennsylvania Hospital was to relieve "the distress of such distemper'd Poor . . . and for the reception and cure of lunatics." The moving spirits behind the construction of this facility were Dr. Thomas Bond and Benjamin Franklin. Dr. Bond's idea for a hospital had received little notice from Philadelphians until he appealed to Franklin.

With the establishment of Pennsylvania Hospital, the colony gained its first institutional focus for the growing medical community. Almost fifteen years before the first medical school opened, the hospital housed the first clinical lectures in America, delivered appropriately by Dr. Thomas Bond. The hospital eventually housed America's first surgical amphitheatre, and, in 1762, began the first medical library. It also had the nation's first outpatient service.

As an institution, the hospital had a superb reputation. From its founding up to the Revolution, Pennsylvania Hospital yearly treated four hundred

patients with a mortality rate of about 10 percent. In reflection of its basic premise, the hospital devotedly cared for "lunatics." One complete floor of the East Wing, constructed in 1755, housed mental cases—a third of the hospital's patients. The hospital also opened its doors to people of all color. Indians were treated, as were blacks. A European observer wrote: "Blacks were here mingled with the whites and lodged in the same apartments."

Throughout Pennsylvania, other hospitals were gradually established. Pittsburgh saw doctors come and go as part of their military assignments. Likewise many small hospitals were established in the Pittsburgh area to meet immediate military or epidemic needs. By authority of Continental Congress, a small hospital was constructed in 1778 following a smallpox epidemic, and named for General Hand. Hand Hospital remained, for 69 years, the only hospital west of the Alleghenies. Pittsburgh still lacked adequate medical facilities. Finally in 1847, through the efforts of crusader Dorothea Dix who decried the lack of care, Mercy Hospital was founded by Bishop Michael O'Connor.

With or without hospitals, medical practice in colonial Pennsylvania was severely limited. The state of medicine was noteworthy for what it lacked. The clinical thermometer, stethoscope, and hypodermic syringe were not yet used. An effective anes-

thesia was years from discovery. A physician had at his disposal certain tools: scales and weights, mortar and pestle, a measuring beaker and a spatula—all needed to mix medicines. There were also scarificators and lancets used to precipitate bleeding, a favored treatment for almost any disease. Knowledge of drugs was rudimentary. For relief of pain, opium or laudanum sufficed. Calomel (mercurous chloride) served several purposes: in large doses it was a purgative or a cure for syphilis, in smaller doses it was an emetic or a cure for diphtheria and scarlet fever.

The colonial doctor seemed bent on prescribing emetics or purgatives, Glauber's salts, Epsom salts, and castor oil typifying the latter. Some treatments had efficacy, although that fact may not have been altogether comprehended. Jesuit's bark, which contained quinine, was good treatment for "ague," or fever frequently malarial-caused. However, to a colonial physician a fever was a fever and Jesuit's bark might be prescribed for any, regardless of cause, with quinine having no effect on non-malarial fevers. Willow bark was also used, which contained a form of aspirin, a drug not then known. In 1762, digitalis was introduced from England as a treatment for dropsy (heart disease). The eternal drug, alcohol, in various forms of beer, wine, or rum was the panacea. Frequently alcohol was the only available anesthetic and pain reliever for the colonial surgeon.

The colonial surgeon was hindered in his practice much as was the colonial physician. For his use, a few basic surgical components were available: "scalpels, lancets, probes, forceps, catheters, sutures, crooked needles, pins, shears, adhesive bandages, pillows for fracture splits, and plenty of linen bandages." Surgeons performed few operations and always in emergency as a last resort. Asepsis was unknown and anatomy was poorly understood. Small wonder that half of all amputations, the most common surgical procedure, ended in death. Of the ideal eighteenth century surgeon, Dr. John Jones, himself renowned as a surgeon, wrote: "He ought to have firm, steady hands, and be able to use both alike, a strong,

clear sight, and, above all, a mind calm and intrepid, yet humane and compassionate, avoiding every appearance of terror and cruelty to his patients, amidst the most severe operations."

This pitiable state of medicine can only be attributed to the great unknowns of scientific knowledge, such as the elementary understanding of human anatomy. Cadavers were scarce. William Shippen, Jr., pioneered in the dissection of human bodies and, in 1765, defended himself against the accusation of "body snatching." An excited mob attacked his house in 1770, breaking some windows, protesting grave-robbing. Until 1867, when the state's first Anatomy Act passed, there was no legal source of bodies for dissection. Even that Act proved inadequate: it applied only to Philadelphia and Allegheny counties and the unclaimed bodies there. Yet another grave robbing scandal, involving Jefferson Medical College's use of illegally supplied cadavers, led to the satisfactory Anatomy Act of 1883.

The causes of diseases comprised another great unknown. Epidemics continually besieged colonial Pennsylvania. Smallpox made an early appearance, travelling along with William Penn on the *Welcome*. Thirty passengers died enroute. One of the most touching stories of early Pennsylvania medicine relates to smallpox. Vaccination was known in the eighteenth century, yet resistance to the practice remained high. In fact, in Massachusetts, where the renowned Puritan minister Cotton Mather, having read reports of the inoculation technique, tried to introduce the practice, public furor reigned. Mather and his house were bombed, though he escaped unharmed. In Pennsylvania, Benjamin Franklin tried to rally support for smallpox inoculation. He movingly wrote: "In 1736 I lost one of my sons, a fine boy of four years old, by the smallpox taken in the common way. I long regretted and still regret that I had not given it to him by inoculation. This I mention for the sake of parents who omit that operation on the supposition that they should never forgive themselves if a child died under it; my example showing that the re-

gret may be the same either way, and that, therefore, the safer should be chosen." Nonetheless, until 1861, smallpox remained a great killer in Pennsylvania and not until 1895 was vaccination mandatory for all school-children.

Other epidemics plagued Pennsylvania, but perhaps yellow fever held a special terror. In 1793, a great epidemic hit, and by its end, decimated Philadelphia's population. Some heroic accounts emerged from this epidemic, perhaps none greater than Benjamin Rush's. Frequently at odds with his contemporaries, Rush cut himself off from various Philadelphians. During the Revolution, he clearly sympathized with the patriots, alienating the wealthy whose tendencies were loyalist. He was one of Pennsylvania's nine delegates to the Continental Congress and was the only M.D. to sign the Declaration of Independence. In 1777, he earned slaveholders' enmity when he published a pamphlet against slavery. While Physician General, he dared to criticize General Washington over lack of supplies. This same man gained fame for his unfaltering devotion to the sick. Throughout the great epidemic, he toiled at sick beds, employing his controversial treatment of blood-letting with vigor. Though his method of treatment was woefully inappropriate, his courage and stamina never failed. All told, 20,000 of Philadelphia's residents fled the city, but Dr. Rush did not even consider leaving to protect himself.

Luminaries, like Rush, helped offset the general lack of medical knowledge. Benjamin Rush pioneered, for example, in humane treatment of the mentally ill. Pennsylvania, in part through its strong Quaker influence, was in the colonial period a leader in attempts to aid those suffering from insanity. Pennsylvania Hospital, where for a time Rush was a staff member, had remarkably advanced facilities for its mental patients. Rooms were dry, clean, with an air ventilation system. There were bathrooms complete for bathing, and an exercise hall. Rush himself held that insanity was an illness rather than "divine visitation." He worked to free mental illness from the moral stigma it carried. In antici-



BENJAMIN RUSH

pation of modern treatment, he advocated occupational therapy, getting spinning wheels for patients' use. In one of history's twists, Rush's son John suffered a complete breakdown in 1808, years after Rush's first interest in mental illness, and was hospitalized for the remainder of his life.

Another shining example for the genius of early Pennsylvania physicians was Philip Syng Physick. In a time when most men in medicine generalized, Physick moved exclusively into the area of surgery. His list of contributions includes invention of surgical instruments, such as a flexible catheter, and innovation in certain procedures: he was the first to use a stomach pump to wash out the contents of the stomach. Using this technique, in 1812 he saved the life of a black child who had ingested laudanum. His successful surgical operations, such as removal of a bladder stone from the 76-year-old Chief Justice John Marshall, are all the more astonishing when one recalls that effective anesthesia was unknown.

Some two hundred years have passed since these beginnings of Pennsylvania medicine. The story of firsts did not end with the close of the Colonial era. Numerous Pennsylvania physicians distinguished their profession in the years to come. For Pennsylvania, the birthplace of American medicine, this Bicentennial observance is neither the first nor the last time the greatness of the Commonwealth's medical contributions will be recalled.

Recurring issues face medicine through the years

ROBERT L. LAMB

Director of Communications

When Governor Milton Shapp at his press conference on May 6 admitted that his personal chiropractor is on the state's payroll, and then went on to give a chiropractic theory of Black Lung Disease, he could have been fulfilling some historical imperative in this Bicentennial year.

Clearly one of the major concerns of the sixty-one physicians who met in the Methodist Episcopal Church in Lancaster at 11:00 a.m., April 11, 1848, to form the Medical Society of the State of Pennsylvania, was the anguish and suffering inflicted upon the public by cultists. The first resolution considered at that meeting said: "It is evident that, for want of some wholesome law to regulate and guard the practice of medicine in the State of Pennsylvania disqualified persons are permitted to impose themselves upon the public in undertaking what

they do not understand, and pretending to what they do not possess, to the great injury of human health, and danger to human life."

From that day until the present the Society has continued to fight quackery. That fight received new impetus in 1973 with the formation of the Committee on Quackery and the Quackery Defense Fund. After three years of voluntary contributions, that fund has produced more than \$47,000.

At this same organizational meeting the Society launched its drive to license doctors. The resolve stated: "That as the guardians of the health and lives of the citizens of this Commonwealth, we respectfully call the attention of Government and the people, to the serious consideration of the establishment of a State Medical Tribunal, without whose authority,

or that of an incorporated college, none shall practice under penalty."

Thus began an organization priority which continues unbroken to today. The latest chapter was written in 1974 with the complete revision of the Medical Practice Act, as recommended by the State Society. In this same resolution may be said to have started the Society's lobbying activities.

In the constitution written during those two days in 1848, the founding physicians also laid down ethical guidelines. Barred from membership in any county medical society was a physician who:

"shall procure a patent for a remedy, or Instrument of Surgery, or who sells or deals in patent remedies or nostrums, or who prescribes a remedy without knowing its composition, or who shall hereafter give a certificate in favor of a patent remedy or instrument. . . ."

Who were these physicians who met in Lancaster to form the Pennsylvania Medical Society? Historian William B. Atkinson, M.D., describes them this way:

"In looking over this list (of sixty-one physicians) we recognize men who have aided largely to make Philadelphia and our state famous in medical science. Men then professors in the colleges, men afterwards professors in these schools, men who have revolutionized medical science."

The convention included representatives from the College of Physicians of Philadelphia, six medical schools, and thirteen county medical societies. Some of the names which still stand out include Alfred Stillé, M.D., Thomas D. Mutter, M.D., and Samuel Humes, M.D., of Lancaster, the Society's first president.

Immunization, a major theme of the



ONE OF THE SOCIETY'S newest activities is the Pennsylvania Medical Cooperative. Shown, left to right, are Jack R. Hogan, Co-op general manager; Robert N. Moyers, M.D., Crawford County, vice president; David F. Gillum, M.D., Tioga County, member of the Co-op Board of Directors; H. Robert Davis, M.D., Cumberland County, president; and Robert Poole, III, M.D., Chester County, secretary.

Society, first saw action in 1848 at the second annual meeting held in Reading. The Society adopted a plan for statewide vaccination against smallpox and then took its plan to the Legislature for implementation through county societies. Later the Society played a key role in securing the requirement that school children be immunized against smallpox. Ironically, by 1972, the risks of smallpox immunization had exceeded the risk of contracting the disease. Following the recommendations of the U.S. Public Health Service, the Society went to the Legislature and asked that the requirement for smallpox vaccination be removed. At the same time it supported a complete revision of the immunization laws giving great flexibility to the Secretary of Health to set requirements in the state.

Today the need for a state department of health is an accepted fact, but such was not always the case. Largely as a result of efforts by the Pennsylvania Medical Society, the Pennsylvania Department of Health was established in 1905. Since then the Society has led the fight to strengthen the Department, a battle which has seesawed through numerous administrations as more and more medical programs for the indigent were assigned to the Department of Public Welfare.

By their third annual meeting delegates began to formally deal with medical education. County societies were advised to set up standards to help members in accepting students into their offices. This concern for medical and postgraduate education has been a principle theme of the Society. In 1860, a minimum course of study for medical students was recommended. In 1863 the Legislature was asked to favor the study of anatomy by dissection. Later the Society sponsored courses throughout the state, particularly in small communities. In 1970, the Society made continuing medical education a requirement for membership. And by the end of the Bicentennial, the vast majority of the Society's 13,000 members will have documented their commitment to this ideal.

In the mid-1930s the winds of American social change began to emerge in the speeches and reports of the Soci-



THADDEUS LEKAWA, M.D., York County, chairman of the Society's Advisory Committee on Membership Recruitment, instructs Ambassadors from Montgomery County in the proper technique for membership recruitment.

ety. Besides its concerns for education and science are added those of public relations and medical economics.

Prophetically, President Alexander H. Colwell, M.D., on Tuesday morning, October 1, 1935, at the Farm Show Building in Harrisburg, in his opening address to the House of Delegates, said: "The most important problems before the medical profession of today are concerned with its social relationships. In common with many other long-established forms of human activity, medicine has been subjected to a very critical survey."

Dr. Colwell went on to comment on the impact of the social planners. "Collectivism is a very ancient social formula which has recently been forcibly revived. The experience of society is that it has always failed. In spite of this unchanging lesson of history, sociologists of our own day are attempting on a much vaster scale than ever before to apply this apparently impossible pattern of human behavior. Among their many schemes is the collectivization of medical practice."

Remarkably, forty years later social planners have still not prevailed, a singular tribute to the outstanding work of private practitioners in the free enterprise setting. Parenthetically, retiring President Dr. Moses Behrend, of Philadelphia, noted the defeat of two bills introduced in the Pennsylvania Legislature proposing compulsory health insurance in Pennsylvania.

Today, membership recruitment is a priority of the society. It can be

traced back to 1935 when the House called for a "concerted effort . . . to bring every eligible practitioner in the state into county society membership."

In 1935 the House approved a recommendation that the Committee on Public Relations "be instructed to make every effort to have the medical profession become articulate in the instruction of high school students engaging in sociologic debates involving European methods of meeting alleged sickness service needs." These and similar public relations efforts continue today in the Society's newspaper, radio, television, speaker's bureau, and other public media activities.

What do these 128 years of Medical Society history tell us—that what men believe counts. And when men believe strongly enough to join together to fight for their ideals, they can achieve their objectives.

In medicine ignorance is the enemy; knowledge and skill the goal. Today PMS is even more committed to medical education than it was 128 years ago.

Although a gullible public has always been willing to be victimized by cultists and charlatans, the profession, then and now, has recognized its responsibility to combat quacks.

But even more fundamental is every doctor's need for freedom to exercise his best medical judgment in behalf of his patients. It is this defense of the doctor's prerogative to which today's physicians must again pledge their devotion.

Alcoholism in Pennsylvania—a Bicentennial perspective

FREDERICK B. GLASER, M.D.

Toronto, Canada

Dr. Glaser presented this paper June 10 at the Lancaster General Hospital FonDersmith Auditorium School for Nurses, Lancaster, as part of the Bicentennial lecture series sponsored by the State Society. Dr. Glaser has adapted the paper to be used as chapter one of a book which he is presently writing. The research for this chapter required a year and a half. The book will be a comprehensive study of the disease of alcoholism in the United States.

Dr. Glaser is head of psychiatry for the Addiction Research Foundation Clinical Institute, Toronto, professor of psychiatry in the faculty of medicine of the University of Toronto, and consultant in psychiatry to the Clarke Institute of Psychiatry, Toronto.

Although he now lives and works in Canada, Dr. Glaser grew up and spent a large part of his life in Pennsylvania. Simon Glaser, his grandfather, was a Latvian immigrant who began as a peddler in the Pennsylvania hills, then established stores in Ulster, Sheshequin, and Sayre. His father was raised in Sayre and Dr. Glaser



spent many of his boyhood summers there.

Prior to his moving to Canada, Dr. Glasser was Robert Wood Johnson Foundation Health Policy Fellow for the Institute of Medicine, the National Academy of Sciences, 1974-75; associate professor of psychiatry for the Medical College of Pennsylvania, 1972-75; associate professor of psychiatry, Temple University Health Sciences Center, and codirector of the Addiction Sciences Center, 1971-72; assistant professor of psychiatry, Temple University Health Sciences Center, and director of Temple's Community Mental Health Center, 1966-71.

All excess is ill, but drunkenness is of the worst sort: it spoils health, dismounts the mind, and unmans men; it reveals secrets, is quarrelsome, lascivious, impudent, dangerous and mad. In fine, he that is drunk is not a man, because he is so long void of reason, that distinguishes a man from a beast.

William Penn
Some Fruits of Solitude, 1693¹

To tell the story of alcohol is to tell the story of mankind. The two are so inextricably intertwined that separation is impossible. Indeed, since carbohydrate-containing fruits, grains, vegetables, and other natural products (e.g., honey) predate man, it is likely that alcohol does as well. Alcohol occurs naturally; all that is required is that fruit or grain be crushed under the hoofs of a passing herd, or that a marauding bear carelessly leave some honey exposed after his depredations. The action of ever-present, simple, and indestructible yeasts will eventually produce alcohol. Hence man was probably exposed to alcohol early in his evolutionary history. Recent biochemical studies, while proposing that the physiological mechanisms of opiate dependence represent a recent engraftment upon a pre-existing system, are reluctant to apply this conclusion to alcohol: "The same argument," writes Collier, "applies to other drugs of dependence, although it is weakened in the instance of ethanol by the possibility that evolving mammals might have been exposed to this substance."²

Man's initial encounter with alcohol is lost in pre-history. Modern commentators wax eloquent in imagining it:

"For alcohol, in contrast to most of our cultural acquisitions, owes nothing to man's creative hand. It comes to us as a triumph not of human imagination but of human curiosity. Like fire, it is a natural phenomenon that man stumbled upon and gratefully bent to his use."³

Man's subsequent encounters enliven and illuminate every age. The Bible presents the humorous picture of Noah in his cups. By the Classical period an extremely sophisticated knowledge of the effects of alcohol is

evident; Anacharsis, a Greek author whose dates are approximately 638-559 B.C., described what in modern terms would be called a dose-response curve: "The vine bears three kinds of grapes: the first of pleasure, the second of intoxication, the third of disgust."⁴

Seneca, the Roman philosopher and statesman (4 B.C. to A.D. 65) felt that "drunkenness is nothing but voluntary madness."⁵ The great German historian Theodor Mommsen, writing of roughly the same period of Roman history, concurred:

"That elegant world of fragrant ringlets, of fashionable mustachios and ruffles—merry as were its doings in the dance and with the harp, and early and late at the wine-cup—yet concealed in its bosom an alarming abyss of moral and economic ruin, of well or ill concealed despair, and frantic or knavish resolves."⁶

More pertinently for the purposes of the present study the English, establishers of the Commonwealth of Pennsylvania, were thoroughly familiar with alcohol in every period of their history. For example, Shakespeare's scene of the drunken porter in *Macbeth* is one of the great comic scenes in literature. Dr. Samuel Johnson and his circle, arbiters of English taste in the eighteenth century, considered questions related to alcohol carefully:

"We discussed the question whether drinking improved conversation and benevolence. Sir Joshua (Reynolds) maintained it did. *Johnson*: 'No, Sir; before dinner men meet with great inequality of understanding; and those who are conscious of their inferiority have the modesty not to talk. When they have drunk wine every man feels himself happy, and loses that modesty, and grows imprudent and vociferous: but he is not im-

proved: he is only not sensible of his defects.'"⁷

In more recent times the poet A. E. Housman sang feelingly of the virtues of man's chosen intoxicant:

"Oh, many a peer of England brews
Livelier liquor than the Muse,
and malt does more than Milton can
To justify God's ways to man.
Ale, man, ale's the stuff to drink
For fellows whom it hurts to think:
Look into the pewter pot
To see the world as the world's not.
And faith, 'tis pleasant till 'tis past
The mischief is that 'twill not last."⁸

It would be frivolous to preface this study with a spate of literary allusions if they did not point to some important lesson. There are several here. First, the realization that alcohol has been an object of human study ever since humans have studied anything is a testament both to the age and to the complexity of the problem. For in spite of his study of alcohol, man has not yet developed a totally satisfactory approach to it. This seeming paradox may be due to a fact which the allusions demonstrate: that alcohol is deeply and thoroughly imbedded in the entire cultural context of human society. It is notoriously difficult to change attitudes or habits which have a strong cultural base. Therefore, in the search for a more rational policy for Pennsylvania one ought to proceed with a measure of respect for this ancient and quixotic substance.

Second, it should be recognized that alcohol is virtually alone among drugs in having such a history. Its only possible rival is tobacco; but, without going deeply into the facts of the case, alcohol appears to be relatively more important. That commonly advanced candidate for substance honors, opium and its derivatives, cannot really compete with alcohol or to-

bacco. Beside them it constitutes a relatively insignificant problem. There is ample reason for this. Opium does *not* occur naturally, at least in a form in which it may readily be utilized. The technology of scoring the opium seed-pod, collecting and treating the resin, and smoking it is far more complex than that of the relatively spontaneous production of alcohol. In terms of the extraction of the active ingredient alcohol has a millennium on opium. Distillation is believed to have been discovered by an Arabian alchemist named Jabir ibn Hayyan, known to the West as Geber (whence the word "gibberish" may derive) in A.D. 800.⁹ It was not until 1806, more than a thousand years later, that Sertürner extracted morphine from crude opium.

The matter of alcohol versus opium will be returned to at the close of this paper, since it does bear upon the current situation in the Commonwealth with respect to the treatment of alcoholism. In the next section, the history of alcohol in Pennsylvania will be dealt with in further detail. But as will already be apparent it cannot be exhaustively covered. To do so one would have to write virtually a complete history of the state. Rather, an attempt will be made to relate some of the more interesting and instructive aspects of the use of the drug within the state, particularly from the earlier period of our history. This will be followed by some consideration of the production, consumption and abuse of alcohol in the state at the present time.

Alcohol and Pennsylvania: yesterday

Nothing could be more indicative of the close relationship between alcohol and history in Pennsylvania than the fact that, as William Penn was sailing to the New World to establish his colony, plans were laid to intercept his vessel, capture Penn and his friends, and sell them into slavery in the West Indies in return for a cargo of rum and sugar.¹⁰ The perpetrator of this scheme was none other than that teetotalling and witch-hunting Boston divine, Cotton Mather. He was probably motivated more by religious zeal than thirst. In his letter to John Higginson detailing

the plot, Mather referred to the Quakers as "heretics and malignants," and to Penn as "the chief scamp"; and he gave his opinion that his deed should be done "so that the Lord may be glorified, and not mocked on the soil of this new country with the heathen worship of these people." Fortunately for Penn and his company, the *Porpoise* under Master Malachai Muscott failed to intercept the *Welcome* as planned, near what Mather was pleased to call "the Cape of Cod"; and a safe landing was effected. Thus began Pennsylvania.

We are informed by a later commentator that its original inhabitants were predisposed by their prior history to the drinking of alcoholic beverages:

"The first adventurers who settled in Pennsylvania, and parts adjacent, having been generally accustomed to the use of beer or ale in Europe, were possessed of an habitual aversion to the drinking of water. They apprehended that the air of this hot climate was unhealthy, and that the water contained some noxious quality. In these opinions they were confirmed, by observing that some persons died suddenly, who had drunk freely of cold water, when oppressed with heat and fatigue; and that severe fevers and agues prevailed in the autumnal season. . . . Hence, through the influence of erroneous prejudices and opinions, the early settlers of the country adopted the practice which prevailed in the West Indies, and introduced the common use of rum, imported from thence, or of an inferior kind, from New England, distilled out of molasses."¹¹

It should perhaps be added that in their propensity to drink they did not therefore differ from most other colonists. "From the day in 1642 that William Bradford [governor of Massachusetts] confided to his journal his astonishment at the growth of drunkenness, the use and abuse of alcoholic beverages has been an important factor in determining the characteristics of American life."¹² The drinking of alcohol was an integral part of early colonial life in America and, some have felt, not particularly problematic; a representative statement is that "in the Colonial period, drinking took place within a

social system in which it was limited and controlled. Drunkenness occurred and was punished, but it was seldom frequent or widespread."¹³

Since no empirical surveys of the incidence or prevalence of alcoholism exist for this period, it is difficult to judge the accuracy of such statements. But that alcoholic beverages were part and parcel of life at the time is well borne out by Penn himself. His country manor at Pennsbury featured a "bake and brew house" with ample provision for the manufacture of large quantities of various alcoholic beverages. Restored in 1938-39, the manor is easily reached by automobile from Philadelphia (Penn himself was the Delaware Valley's first commuter, but used the river to get to Philadelphia daily) and is located near Tullytown and the eastern terminus of the Pennsylvania Turnpike. The brewing portion of the building occupies half of the structure, is conveniently located near the kitchen door of the manor house, and possesses, among other things, a vat of sufficient capacity to astonish the casual observer. Moreover, the estate even today produces items frequently utilized in colonial times to make alcoholic beverages. There are apples (cider), pears (perry) and honey (mead), in addition to the grains needed to make beer. The Penn Family Recipe book survives and substantiates the use of these raw materials and others besides. Those who may have wondered why Philadelphians drink to this day large quantities of birch beer may find Recipe Number 99 to be interesting as well as strangely poetic:

"Too Make Burtch, by a friend at the Clift in Lewis:
Bore a hole through a burtch tree
and
putt in a faset,
and putt sumthing under,
and when tis full boyle it of every 2
days
with 2 pound of white sugger too a
gallan,
and when it is almost Cold,
work it up with a Little yeist,
then put it up in Veselles
obsarve that the time to sane it is in
March
and at the beginning of Aprill



DR. GLASER is shown above on the left being interviewed at FonDersmith Auditorium at Lancaster General Hospital following the lecture. On the right, the author chats with Nikitas J. Zervanos, M.D., member of the Society's Council on Education and Science, who arranged the series of lectures for the Society under the Council's direction. Dr. Zervanos is director of the Family Practice Residency Program at Lancaster General Hospital.

if it be a forward spring it will scarce
Run
at all April!"¹⁴

Nor was Penn's taste for alcoholic beverages unusual. In 1685, only three years after the bungled interception by Cotton Mather, correspondence suggests not only that his fellow colonists shared his penchant for drink but that commercial brewing had already begun in Philadelphia:

"Our DRINK has been *Beer* and *Punch*, made of *Rum* and *Water*: our Beer was mostly made of Molasses, which well boyld, with *Sassafrass* or *Pine* infused into it, makes very tolerable drink, but now they make *Mault*, and Mault drink begins to be common, especially at the *Ordinaries* and the Houses of the more substantial People. In our great Town there is an *able man*, that has set up a large *Brew House*, in order to furnish the People with Good Drink, both there and up and down the River."¹⁵

If this rather idyllic picture of a general and relatively carefree consumption of alcohol was indeed accurate it was, by general agreement, not of very long life. The eighteenth century was "not many years old," according to Krout, "when a change came over colonial drinking customs. It was caused largely by the increasing popularity of distilled spirits in general, and rum in particular."¹⁶ Anthony

Benezet, a Quaker of French origins known principally for his active opposition to slavery, observed that by 1728 "the introduction and consumption of rum had made an amazing progress, and began to rouse the attention of some of the considerate, may I not say, of the lovers of the country in that day."¹⁷ By balancing the imports and exports of rum as reported in the *Pennsylvania Gazette* for that year he calculated the yearly consumption of rum in the state at 25,000 pounds. Indeed, as early as 1721 the Philadelphia Friends had encouraged a movement to prevent the sale of "ardent spirits" in the province and to encourage the brewing of beer as a substitute.¹⁸ And by 1744 a Philadelphia Grand Jury whose foreman was Benjamin Franklin presented a report deploring the existence of over one hundred public houses in the city "and representing that the court exercise more freely its power of suppression."¹⁹

Despite these alarms and excursions, drinking in Pennsylvania apparently flourished in an uninhibited and almost exotic manner. The die was cast early. From Colonial times to the present, the pattern has been one of continued and increased drinking, and increasingly strident efforts to stop it, culminating in the Great Experiment of Prohibition and its failure. To date all measures designed to

abate the use of alcohol have been generally ineffective. This may be seen from a description of drinking in Pennsylvania as of 1750-54, the exact middle of the eighteenth century. The writer is an ingenuous German observer, Gottlieb Mittelberger of Enzweihingen in the duchy of Wurtemberg, Germany. It fell to Mittelberger's lot to accompany to America a consignment of organs which had been ordered by the famous Lutheran clergyman Henry Melchoir Muhlenberg. Fortunately he recorded his impressions, and among them is a description of drinking, eighteenth century Pennsylvania style. Remember that this is some thirty years *after* the serious movement against spirits reported above had begun:

"Many kinds of beverages are available in Pennsylvania and the other English colonies. First of all, excellent and salubrious water; secondly, people drink a mixture of three parts of water and one part of milk; thirdly, there is good cider; fourthly, small beer; fifth, delicious English beer, strong and sweet; sixth, so-called punch, made of three parts water and one part West Indian rum (where there is no rum, one can use brandy, but rum is much more pleasant), mixed in with sugar and lemon juice; seventh, sangaree, which is even more delicious to drink—this is made out of two parts of water and one of

Spanish wine with sugar and nutmeg; and then, eighth, German and Spanish wines, which are obtainable in all taverns."²⁰

An act was passed in the Pennsylvania legislature in 1750 against "so manifest an evil," prohibiting the practice of giving out spirits on public occasions such as vendees under pain of a fine. But it also seems to have been ineffective. This may be inferred from the appearance in 1774 of a tract by Anthony Benezet. In its vehemence, polemical tone the coming crusade for prohibition is clearly foreshadowed, and indeed Benezet was the spiritual father of the movement. His pupil, Dr. Benjamin Rush, was to write the most famous of all anti-alcohol pieces, and Rush's piece in turn inspired those who were the direct historical ancestors of the prohibition movement, such as Lyman Beecher of Massachusetts and the Moreau (New York) Union Temperance Society, the first temperance society in America.

Benezet's book, which was published in his hometown of Philadelphia by Joseph Cruikshank, "between Second and Third Streets, in Market-Street," was entitled "The Mighty Destroyer Displayed, in some Account of the Dreadful Havock made by the mistaken Use as well as Abuse of DISTILLED SPIRITOUS LIQUORS, by a Lover of Mankind." Benezet did not include all alcohol-containing beverages in his indictment, but simply those with a higher alcohol content, a lead followed by his pupil Benjamin Rush. Recent research²¹ has implicated *all* classes of alcoholic beverages in alcoholism, and in fact has suggested that wine rather than distilled spirits may be the most common tippie of alcoholics,²² though this may not have been the case two centuries ago.

The intensity of Benezet's feeling cannot be overstated. He described the drinking of distilled liquors as: "An evil so amazingly great, that did not seem experience too fully prove it, it seems incredible, that any whom it concerns could possibly be so negligent, as not to use their utmost endeavors to suppress this destructive *manbane*."²³

Much of the pamphlet is given to various descriptions of physical prob-

lems allegedly due to alcohol which were extracted from English medical periodicals of the time. As these were not widely circulated in the colonies, Benezet felt he was performing a useful service. It is worth noting that his concern about alcohol was not unrelated to his concern about slavery. He believed that "... it is, in a great measure, through the introduction of these infernal spirits, that the poor Negroes have been as it were bewitched, and prevailed upon to captivate their unhappy country people, in order to bring them to the European market. . . ."²⁴

Of particular interest is that Benezet proposed a preventive measure against the consumption of distilled spirits that has recently been revived: taxation.²⁵ Balancing the possible gains from the sale of distilled spirits against its liabilities, Benezet urged: "Let such lawmakers, governors, and rulers, who retain any pity for their fellow men; let *these* be earnestly requested seriously, and solemnly to consider, whether it is not their indispensable duty to use their utmost endeavors, that a stop may be put to this dreadful calamity; let not the apprehension of loss or any present inconvenience, deter any from doing their duty in this respect, because there cannot any inconveniences possibly arise from the redress of this grievance, which deserves to be named with those evils which will be the undoubted consequence of its continuance. The reasons which have hitherto prevailed to the countenancing of this most destructive practice ought surely to be rejected with scorn and indignation, when the welfare of such numbers are so deeply concerned. What multitudes of lives would thereby be saved, and what innumerable outrages, as theft, murder and crime prevented: To rectify which, drunkenness is made the cheapest of all vices. A device which can no otherwise be effectually prevented from raging with its present excessive enormity, and spreading devastation all around, but by laying such high taxes upon distilled spiritous liquors, as well as those made amongst us, as those imported from abroad, as will make the drinking it sufficiently expensive to put it out of the reach of so great a number of in-

satiable drinkers, to use it; at least in its present degree of strength."²⁶

It does not appear that Benezet's tract greatly affected his countrymen. In view of the impending Revolutionary War and its consequent upheavals, it may have gone largely unnoticed. But both Benezet's tract and his personal teachings profoundly affected one of his pupils, a man who played an important role in the Revolution as well as in American medicine. Benjamin Rush (1745-1813), who referred fondly to Benezet as "one of the most laborious schoolmasters I ever knew"²⁷ was a member of the Continental Congress and the only physician to be a signer of the Declaration of Independence. Edinburgh-trained, he became professor of medicine in the Philadelphia Medical College. He is considered the father of American psychiatry; his likeness adorns the seal of the American Psychiatric Association. Currently his home in Philadelphia is being restored as a project of the Bicentennial celebration, and he appears as a character in one of the plays being presented in connection with that event.

In 1785, Rush published a pamphlet whose lengthy title is reminiscent of his teacher's style: "An Inquiry into the Effects of Ardent Spirits upon the Human Body and Mind, with an Account of the Means of Preventing and of the Remedies for Curing Them." It was the first American medical treatise on alcohol, and was enormously popular, going through many editions and being widely distributed.

If his teacher Benezet was strident about distilled spirits, Rush was apoplectic. He was hardly able to restrain himself in his detestation. Of its effects upon men he wrote: "In folly, it causes him to resemble a calf,—in stupidity, an ass,—in cruelty, a tyger,—in fetor, a skunk,—in filthiness, a hog,—and in obscenity, a he-goat.

Those who may have hoped for a restrained and objective tone from a professional observer will not find it here. Nevertheless the work is not without its humor, and provides some fascinating vignettes of clinical cases of alcoholism in the Revolutionary era. A few of these are perhaps of interest here:

"There was a citizen of Philadelphia many years ago, in whom drunkenness appeared in this protracted form. In speaking of him to one of his neighbors, I said, 'Does he not *sometimes* get drunk?' 'You mean,' said his neighbor, 'is he not *sometimes* sober?'"

"I have sometimes seen (this remedy) used when a boy. In the city of Philadelphia, it was applied, by dragging the patient, when found drunk in the street, to a pump, and pumping water upon his head for ten or fifteen minutes. The patient generally rose, and walked off, sober and sullen, after the use of this remedy."

"A citizen of Philadelphia had made many unsuccessful attempts to cure his wife of drunkenness. At length, despairing of her reformation, he purchased a hogshead of rum, and after tapping it, left the key in the door of the room in which it was placed, as if he had forgotten it. His design was to give his wife an opportunity to drink herself to death. She suspected this to be his motive, in what he had done, and suddenly left off drinking. Resentment here became the antidote to intemperance."

As merciless as was Rush toward "ardent spirits," he was nevertheless a physician who regarded the welfare of his patients above all else. Upon them he did not vent his rage, but he rather made an eloquent plea for their compassionate care. None more moving has ever appeared. A modern treatment program could do little better than to adopt as its credo what Benjamin Rush wrote a century ago: "I am aware that the efforts of science and humanity, in applying their resources to the cure of a disease introduced by an act of vice, will meet with a cold reception from many people. But let such people remember, the subjects of our remedies are their fellow creatures, and that the miseries brought upon human nature, by its crimes, are as much the objects of divine compassion (which we are bound to imitate) as the distresses which are brought upon men, by the crimes of other people, or which they bring upon themselves, by ignorance or accidents. Let us not then pass by

the prostrate sufferer from strong drink, but administer to him the same relief, we would afford to a fellow creature, in a similar state, from an accidental and innocent cause."

As was the case with his teacher, Benezet, Rush's efforts did not bear immediate fruit. Palmer, an Englishman who visited Philadelphia in 1818, five years after Rush's death, remarked upon the great variety of taverns and tavern-boards there:

"We observed several curious tavern signs in Philadelphia and on the roadside, among others Noah's Ark; a variety of Apostles, Bunyan's Pilgrimage; a cock on a lion's back, crowing, with Liberty issuing from his beak; naval engagements in which the British are in a desperate situation; the most common signs are eagles, heads of public characters, Indian Kings &c."²⁸

But Rush had lighted a torch. It was not for nothing that he was dubbed by latter-day temperance workers "The True Instaurator," or inaugurator, of their movement. His work was to reach fruition more than a century from the time he originally wrote, and when the character of the country had changed considerably. But that the country had begun to change during his lifetime is clear from another notable Pennsylvania event which occurred less than a decade after the first edition of his pamphlet appeared: the Whiskey Rebellion.

One of the major attractions at Walt Disney World in Orlando, Florida, is the Hall of Presidents. It is located in a structure whose facade is an attempt to replicate Philadelphia's Independence Hall. (The visitor to Disneyland in California will not find a Hall of Presidents, though one is planned for a future time; he may, however, see another reproduction of Independence Hall at nearby Knott's Berry Farm.) Within the Hall the principal attraction consists in the animated effigies of all the Presidents of the United States, who speak and gesture in a lifelike manner. They are under the general direction, it would appear, of President Lincoln. Critics have scoffed at the alleged superpatriotism which they feel underlies such an exhibit. But to one observer, at least, the results were impressive;

and the effect upon children is remarkable.

Following the brief animated presentation a rather more lengthy and detailed film is shown which has to do with the history of the Republic. It is this film which is significant for our present purpose. For after the initial discussion of the Revolutionary War and the events related to it, the subsequent story of the United States unfolds. The very first chapter in that story is the Pennsylvania Whiskey Rebellion. Adults of the present generation will not recall this sequence from their course of instruction in American history; but that is because only very recent events have called attention to this episode as one of great significance, as indeed it was viewed at the time. The intervention of armed Federal troops at Central High School in Little Rock and at the University of Alabama had its direct precursor in events in Pennsylvania at the close of the eighteenth century. Because of their importance and their connection with alcohol, these events will be briefly recounted.

Although it had been victoriously prosecuted, the War of Independence had not been inexpensive. When it was over the newly united states were in desperate need of financial resources. Under the leadership of Secretary of the Treasury Alexander Hamilton a search was therefore made for revenue. In the spring of 1791 the congress enacted Mr. Hamilton's proposals. They included duties upon imports and an excise tax upon certain products, prominent among which were distilled spirits (there is no direct evidence that Hamilton was influenced in this action by Benezet and Rush, though that is not impossible).

The new whiskey tax fell heavily upon western Pennsylvania. "Pennsylvania was the banner state, and western Pennsylvania the banner section, in this industry."²⁹ Interestingly the reasons for this had to do more with transportation problems than with the desire to consume distilled spirits. The Pennsylvania mountains were at that time a serious impediment:

"The rich region raised grain greatly in excess of the needs of its inhabitants, but it cost more to transport a

barrel of flour over the mountains than it would sell for in the markets of the east. So it was with the fruits of the region. But when these were distilled into spirits, they could be transported more readily, and sold at a profit. A horse could pack but four bushels of grain, but it could easily transport the product of twenty-four bushels in the form of distilled liquor."³⁰

Given these circumstances alone, it is not surprising that there was great opposition to the new tax in western Pennsylvania. But there were additional and contributory reasons for the opposition of the populace. Many were of Scotch-Irish extraction, and had a history of past resistance to taxation. The French Revolution had just begun; its anti-governmental ideology added fuel to the fires. The several border wars which had been fought in the area had given to the inhabitants a character of independence and self-determination quite apart from that of other regions. These were the frontiersmen of their day. In fact, there had been secessionist sentiment in this area before. Many people felt more loyalty to Virginia than to Pennsylvania and resented their land being considered a part of the latter state. Finally, on account of the relative remoteness of the country, it was believed unlikely that the new excise provisions could be effectively enforced by a distant federal government.

When some of the region's more responsible leaders such as Albert Gallatin [whose statue stands in front of the U.S. Treasury Building in Washington, D.C.] joined the opposition, the fat was in the fire. They were joined by less levelheaded and more demagogic leaders like David Bradford, a lawyer of some renown and a deputy attorney general of the state. There was increasing agitation. When attempts were finally made to collect the revenue, people turned violently upon the collectors. Several were tarred and feathered, and their homes were destroyed. A secret terrorist organization under the symbolic leadership of one "Tom the Tinker" sprang up. "A distiller who had the hardihood to go counter to the prevailing sentiment and entered his still for taxation, found a notice posted up in the night at his door, warning him

that unless he aligned himself with the opposers of the excise, "Tom the Tinker" would pay him a visit and mend his still!"³¹

When the federal congress responded to this pressure by modifying and abating its demands, the determination of the people of the region to resist was greatly strengthened. President Washington finally issued a proclamation that the excise provisions would be enforced and warned all persons not to interfere. General John Neville was appointed inspector of the excise for the area. By the time he was able to mount a determined effort to collect the taxes, toward the middle of 1794, feelings were running extremely high. The spark which lit the conflagration occurred in July of that year when General Neville and Major Lenox, a United States Marshall, served a writ on a farmer living near the border of Allegheny and Washington Counties. They were attacked on the road subsequently and shots were fired, though no one was injured.

A party of local citizens quickly gathered and, on the following morning, made an armed assault upon General Neville's home in the Chartiers valley. They were repulsed by the general's household servants and suffered at least one casualty. Regrouping on the following day they attacked the house with a force of six hundred. It was taken and destroyed, and the lives of its occupants were threatened; but fortunately they were aided in escaping by some less rabid members of the opposition. The next major event was a mass muster of some seven thousand opponents of the excise at Braddock's Field near Pittsburgh. This small army appeared for a while to pose a serious threat to the survival of the city of Pittsburgh. Though tragedy was eventually deflected by the good sense and strenuous exertions of levelheaded persons on both sides, it was clear that the situation had deteriorated to a point where decisive action was required.

General Washington was not one to hold back when his mind had been made up. He defined what had occurred as treason—in his words, "overt acts of levying war against the United States."³² An army of 12,950 troops was immediately raised in

Pennsylvania, Maryland, Virginia, and New Jersey. It was much better equipped and greater in size than the force he had commanded at Yorktown, and cost approximately a million dollars, a considerable sum in those days.³³ General Henry "Light Horse Harry" Lee, hero of the Revolutionary War (and father of General Robert E. Lee) was placed in charge. Other generals included the governors of Pennsylvania and New Jersey. The army was accompanied by Alexander Hamilton throughout its maneuvers. General Washington himself came out as far as Carlisle, where he personally heard a deputation from the western region. The deputation attempted to work out a compromise. Washington would have none of it and ordered the troops on.

The effect of this massive and definitive action was overwhelming. General Daniel Morgan, a member of the staff of the Army, wrote a letter home saying that "the alarm that these people have experienced is so great that they will never forget it, so far as to fly in the face of the law again."³⁴ Opposition melted and capitulation was complete. There were no battles. Order was restored. Fortunately the army was well commanded and its troops were successfully kept from revenging themselves upon the local population in return for the bitter and intemperate insults which had been directed at them. Collections on the tax were begun with no difficulties, and after a period of garrison duty the army was dismissed with the thanks of the government. Nor did the incident repeat itself; with the opening up of the Ohio Valley after the Indian Campaign of General Anthony Wayne, a new and better market was found for the whiskey and commerce was improved to the point where as early as 1802 the tax measure could be repealed.

Historians have differed as to whether Washington's truly massive response was justified. One suggested that "the national government showed a little weakness in making a foolish exhibit of its strength."³⁵ But another view is that: "This action was not due to any sudden panic on the part of the great general and president, who for three

years had been earnestly and patiently trying to compose the differences without resort to force, but came from his appreciation, with all the facts before him, that it was a grave crisis, requiring heroic treatment. No one who looks carefully at all the facts can well escape the conviction that the ship of state was among the breakers which had well nigh wrecked it."³⁶

Essentially the action demonstrated once and for all that the United States did have a federal government which was both willing and able to enforce its will on certain issues over that of the separate states by utilizing methods up to and including the deployment of its troops. While this principle has been tested on several occasions, most notably during the Civil War and recently during the era of civil rights activism, the early episode in Pennsylvania set the pattern for all that happened subsequently. Thus the Whiskey Rebellion occupies a niche of great significance in the history of the United States.

It is fitting that at this point the particular history of alcohol in Pennsylvania be brought to a close. With the emphatic establishment of the union in an action related to the production of alcohol, alcohol's history passes from the local to the national scene. It becomes no longer a local matter but an important item in interstate commerce (see above), and its history is less uniquely connected with Pennsylvania or any other state than with the development of the country as a whole. Further, by this time the basic scenario with respect to alcohol has been well established. Essentially it is a continuing story of the increased use of, and increased opposition to the use of, alcohol in its many forms, culminating in Prohibition. It is a national, not a local story, and is one which has been well told on more than one occasion.^{37,38} As for the aftermath of Prohibition—that is, the continuing attempt of a small group of states to exercise restraint over the sale of alcohol by a variety of means—Pennsylvania played an important role here, setting up the first of the state monopoly systems. While this has been and continues to be a matter of considerable controversy,

it is the subject of a special report and will not be further discussed.

It may be useful now to review the production and consumption of alcohol in the Commonwealth at the present time, and then to consider briefly how the citizens of Pennsylvania have gone about dealing with those of their number who have used the drug to excess.

Alcohol and Pennsylvania: today

Pennsylvania is both a producer and a consumer of all categories of alcoholic beverages. This is so despite many efforts which have been made to curtail these activities. A certain amount of the consumption of alcohol in Pennsylvania is excessive consumption, and those individuals who engage in this kind of consumption may be termed alcoholics. (It should be noted that, for some, this is a simplistic definition of alcoholism). In this section an attempt will be made to approach the gross parameters of the production and consumption of alcohol as it currently exists in the Commonwealth.

For purposes of simplicity we shall consider production and consumption of the three major classes of alcoholic beverages: wine, spirits, and beer. All data are derived from the most recent editions of the national trade publications in each of these areas: the *Wine Marketing Handbook*, the *Liquor Handbook*, and the *Brewer's Almanac*.^{39,41} Production will be considered first.

Wine—Pennsylvania is not a major wine producer. Until 1968 commercial wineries were not permitted to operate in the state. In that year an act was passed which permitted limited operations. A ceiling of 50,000 gallons per winery per year was imposed. Fruit used to make the wine must be grown in Pennsylvania, and marketing opportunities are closely restricted; in the main, purchases may be made only at the site of the winery. Nevertheless in fiscal 1973 Pennsylvania produced 37,637 gallons of still wine, ranking seventeenth among 26 states which produce. The leading states in this field are California, with an annual production that year of more than 284 million gallons, and New York with over 31 million gallons.

With respect to sparkling wines Pennsylvania is eighth in a field of eight producers, the leaders being California with almost 16 million gallons and New York with approximately four million. Pennsylvania's output of sparkling wine in the same period was just above 3,000 gallons.

Spirits—The Commonwealth produces a moderate amount of spirits. In fiscal 1973 a total of 329,182 tax gallons were produced, giving Pennsylvania a ranking of seventh among 10 producing states. In that same year Kentucky, the leading state, produced 71,511,674 tax gallons. Four of the 65 regular distilleries in the United States were located in Pennsylvania at that time, whereas 34 of the 65 were in Kentucky.

Beer—Pennsylvania is a major producer of beer, ranking (in 1972) seventh among all states, every one of which is a producer, including the District of Columbia. The state's total production in that year was 6,585,345 barrels (there are 31 gallons in a beer barrel). This is slightly more than a third of the production of the leading state, Wisconsin, which during that same time produced 15,587,903 barrels. However, it is of interest that in that year both states had the same number of breweries—twenty each. Thus Wisconsin's advantage is that its breweries are very large, while the Keystone State is known to the brewing industry as "the home of small breweries." (It is perhaps worth noting here that John Wagner of Philadelphia brewed the first lager beer in the United States in 1840.⁴²) Pennsylvania also treats its breweries in a kinder manner than Wisconsin. Ten years ago there were 30 breweries there as compared with 25 in Pennsylvania, so that Pennsylvania's attrition rate for breweries is only half that of Wisconsin over the decade.

Consumption data—Pennsylvania is a low consumption state in terms of wine and spirits, but ranks fourth in the consumption of beer. It is 41st among the states in adult per capita consumption of spirits and 45th in terms of consumption per \$1 million of income. It is 29th among the states in adult per capita consumption of wine and 31st in consumption per \$1 million of income. The closeness of

TABLE I
Consumption of Alcohol in Pennsylvania

Beverage	Average Annual per capita Consumption, gallons*		Assumed Absolute Alcohol Content**	Annual Absolute Alcohol Equivalents in ml per capita	
	United States	Pennsylvania		United States	Pennsylvania
Beer	19.10	21.40	5%	3,371.62	4,047.00
Wine	1.61	1.12	16%	975.10	675.13
Spirits	1.92	1.44	40%	2,667.04	2,180.34
				7,013.76	6,902.47

*Sources for these data are: *The Liquor Handbook*, 1973; *The Wine Marketing Handbook*, 1974; and *The Brewer's Almanac*, 1973.
 **These figures are suggested by the Addiction Research Foundation of Toronto in their publication *Proposal for a Comprehensive Health Oriented Alcohol Control Policy in Ontario*, April 1973, p.1 of Appendix 1.

these figures suggests that income levels are not a significant determinant of the lowered consumption rates in Pennsylvania for wine and spirits. It is worth noting that the consumption of those beverages which are controlled by the state liquor monopoly in Pennsylvania (wine and spirits) is low, while the consumption of that beverage which is *not* so controlled (beer) is high.

Specific data as to the consumption of alcohol in Pennsylvania are portrayed in Table I and compared with national averages. While the state is below average in the consumption of wine and spirits, it is above average in beer consumption. In terms of absolute alcohol equivalents there is little in the way of overall difference between average American and Pennsylvania consumption. (The difference, which amounts to .16 gallons of absolute alcohol, would not sustain an alcoholic for four days.) The average Pennsylvanian consumes just under two gallons of absolute alcohol each year, or slightly less than the average American.

Alcoholism—At this point one might ask whether there exist data which provide an appreciation of the relative or absolute size of the problem of alcoholism in Pennsylvania. The overall answer seems to be that some general indication can be given in both categories, but that all such figures need to be seriously qualified. Figures on the absolute incidence of alcoholism are difficult to interpret because there are problems in both the direct and the indirect measurement of alcoholism and, beyond this, in obtaining agreement on the nature of alcoholism. Figures on the relative

incidence of alcoholism are difficult to interpret because the same measures are rarely utilized to measure alcoholism in different jurisdictions. Technical details of these arguments are too lengthy to be entertained. Here the data which are available will be summarized.

There have been two major attempts recently to estimate the overall number of alcoholics in Pennsylvania. The first of these is contained in the Pennsylvania State Alcohol Abuse and Alcoholism Plan for 1971-72.⁴³ The estimate is based on reported deaths due to cirrhosis of the liver and utilizes the Brenner modification of Jellinek's formula. Based on 1,812.5 average annual deaths from cirrhosis in the period 1969-70 for the entire state, it is estimated that there were in that period 944,011 alcoholics in Pennsylvania. Other ways of expressing this figure are that 8 percent of the overall state population or 11 percent of its adult population suffered from alcoholism.

A second major attempt at estimation was based on a survey done in the spring of 1973. Using criteria related to the consumption of alcohol, Schaps and Rubin⁴⁴ estimated that there were 631,508 abusers of alcohol, or that 7.3 percent of the adult population were abusing alcohol. The survey data also permitted a calculation of the drinking population, in that 21.8 percent of the survey population indicated they did not drink at all. Hence, it could be estimated that there were 6,726,169 drinkers in Pennsylvania among the adult population, and that there was roughly one alcoholic for every ten persons who drank at all.

Beyond noting that the ranges do

not differ greatly between the two studies there is no real way to decide between them. Hence we can say only that there may be between 6.32×10^5 and 9.44×10^5 alcoholics, or that between 7.3 percent and 11 percent of the adult population are alcoholics. Just how this compares with other states is quite problematic. However, one may note that a careful national sample⁴⁵ revealed an incidence among adults of 9 percent, a figure which is almost exactly in the middle of our two most recent estimates. Since Pennsylvanians approach the national average in terms of the consumption of absolute alcohol (Table I), and there is evidence⁴⁶ of a linear relationship between consumption of alcohol and alcoholism, it is tempting to conclude that Pennsylvania is probably at the national average in terms of the number of alcoholics per 100,000 citizens. Until there are considerable improvements in the ability of both Pennsylvania and the nation at large to measure the incidence and prevalence of alcoholism, both cross-sectionally and longitudinally over time (something which seems a necessary prelude to any rational alcohol policy), such a statement may serve as the best we can do at the moment. Certainly any problem which affects hundreds of thousands of Pennsylvanians merits the most serious attention.

Treatment—yesterday (1840-1959)

What sort of attention has the problem received? For a number of reasons, this is not an easy question to answer. Much of the effort put forth over the years to assist the alcoholic

has gone unreported. Many individuals, among them physicians, clergymen, and numerous lay people, have contributed but have not recorded their work. They have failed to do so partly out of modesty. In addition, they have seen the assistance which they rendered not as a particular type of help given to an individual with a particular type of problem, but as merely a part of their general helping effort, whether it be to save bodies or to save souls. There has not emerged a separate and distinct alcoholism treatment effort. Rather (for the most part) assistance to the alcoholic has been rendered as a part of general assistance to the ill and needy, at least until recently.

Hence it is difficult to do justice to all who have played a role in the process. What follows is necessarily incomplete and does not give sufficient credit to many. Regrettable as this may be it is nevertheless useful to bear in mind, for it anticipates the major conclusion of this study: that society has not yet come to grips with the problem of alcoholism in any systematic manner, and a systematic record of the alcoholism treatment effort does not exist. An attempt will be made to sketch what has been done in the past in this paper; but the limitations of the study should not be overlooked.

As nearly as can be determined, the notion that alcoholics constitute a group of people who ought to be helped is relatively recent. Not until the founding of the Washingtonian Movement in 1840 was any large-scale effort made, and this despite the fact that the temperance movement had begun some time before. The temperance movement was preventive, not therapeutic. It was designed to keep people from succumbing to the vice of alcoholism, not to rescue them from it once they had "fallen." Dr. Harrison in 1860 attributed this in part to a class bias in the temperance movement, noting that "our temperance friends were, generally, men in higher circles of life, who would revolt at the idea of taking a drunkard by the arm in the street and walk with him in some place where he could be made sober and receive friendly advice."⁴⁷ Milton Maxwell has summed up the situation quite well:

"As for the alcoholic, it was the prevailing opinion, up to 1840, that nothing could be done to help him. Occasionally a "drunkard" did "reform," but this did not erase the general pessimism as to the possibility of rehabilitating drunkards. Since alcohol was held to be the 'cause' of alcoholism, the temperance movement was aimed solely at keeping the non-alcoholic from becoming an alcoholic. This implied indifference to the alcoholic was epitomized by Justin Edwards in 1822: 'Keep the temperate people temperate; the drunkards will soon die, and the land be free.'"⁴⁸

This unfortunate situation was altered, however briefly, by the formation and propagation of a remarkable organization known as the Washingtonian Society. Arising from the efforts of a group of drinking cronies in a Baltimore Tavern in April, 1840, the Society was essentially a self-help movement among the afflicted. In that sense it was an earlier precursor of Alcoholics Anonymous, though the historical connections between the two movements are in reality rather tenuous. AA seems mainly to have learned from the mistakes of the former effort. Somehow, the Washingtonian idea took hold. Propelled by several charismatic individuals and spellbinding orators, such as John Gough, the movement had an almost incredible vogue for a few brief years, though it was essentially over by 1848.

As is the case with many other self-help movements, the Washingtonian Movement resembled an evangelical and religious effort.⁴⁹ Mass meetings were held at which former drunkards recounted the almost miraculous tale of their reformation, aided by the brethren of the Society, and urged others to come forward and be helped. "No fiction could be more exciting or dramatic. These true-life narratives pulled at the heartstrings. They aroused awe and wonder at the 'miracle of rebirth'."⁵⁰ In June of 1841 the team of Jesse Vickers and Jesse W. Small began a campaign in Pittsburgh, where "all classes, all ages, all ranks and denominations, and both sexes, presses every night into overflowing churches." In a brief time, 10,000 were pledged, 'including a multitude of the

most hopeless characters.'"⁵¹ Both Philadelphia and Pittsburgh were considered centers of the movement, and it was estimated that in and around Philadelphia (where for some reason the societies were called Jeffersonian rather than Washingtonian) some 20,000 members were enrolled.

The fervor did not last long. While the Washingtonians were initially useful to the temperance movement, they became something of an embarrassment when the novelty wore off, especially as some of their more prominent spokesmen regressed to the bottle. Moreover, they eschewed the political and legalistic maneuvers which began to appeal increasingly to the temperance movement and were to become their eventual means of triumph (Prohibition was essentially a tribute to the astute politicking of Wayne B. Wheeler, the formidable General Counsel of the Anti-Saloon League).⁵³ Finally, like many evangelical movements, the participants fell to bickering among themselves and split into factions. In essence, the movement burned itself out. Small remnants survived; there is yet a Washingtonian Institution in Boston, now newly revived and effectively functioning. But the history of the Washingtonian Movement serves principally to illustrate the fact that little was being done to help alcoholics in mid-nineteenth century America.

A generation later, in the period of the 1870s, there appeared an association of lay and professional people who had become convinced that alcoholism was a special problem and required special treatment, and who set about to provide the same. The American Association for the Cure of Inebriates was a loose confederacy of institutions and individuals. Its origins were apparently multi-focal; for example, the Pennsylvania Sanitarium at Media had been founded some time before, in 1866. Joseph Parrish, M.D., its director, scion of a proud Philadelphia medical family (and ancestor of the late great artist Maxfield Parrish), became president of the association and was one of its leading lights. By 1874 the association listed nine institutions as members. They included the Washingtonian Homes in Boston and Chicago

TABLE II

Institutional Care in the United States and in Pennsylvania on January 1, 1917.
Data are from Pollock and Furbush.⁶¹

Class of Individual	Number in Institutions	
	United States	Pennsylvania
Insane	234,055	19,436
Feeble-minded	37,220	4,361
Epileptics	10,801	645
Inebriates	4,891	429

and the New York State Inebriate Asylum at Binghamton. Two institutional members are listed for Pennsylvania: the Franklin Reformatory Home for Inebriates at 913-15 Locust Street in Philadelphia, and the Inebriate Department of the House of Corrections, also in Philadelphia. (The Media Sanitarium is not listed in 1874 and Parrish appears in the rolls of that year as the superintendent of Harlem Lodge in Baltimore; apparently the institution had folded.)⁵⁴

The major thrust of the Association was to promote separate treatment for alcoholics. In his presidential address of September 28, 1875, Joseph Parrish reported with evident satisfaction that the superintendents of hospitals for the insane, at their recent annual meeting, had come out for separate inebriate institutions "for the reason, that the presence of inebriates in the hospitals under their charge, is injurious to the insane."⁵⁵ While it was understandable that the superintendents should feel this way, Parrish was more concerned for his own. In the instructions to patients at Media appeared the following: "You are not insane, and do not require the restraints of insanity. You are morally infirm, and need self-discipline and culture. You are physically diseased, and need medical treatment."⁵⁶

At least on a temporary basis the association met with some success. Some of its institutions were fairly substantial. In an 1871 report Media claimed 186 admissions for "alcoholic inebriety" and 14 admissions for "opium inebriety."⁵⁷ The Franklin Reformatory Home reported 112 admissions and 44 re-admissions during its first year of operation.⁵⁸ A typical case summary from the superintendent's report of the Franklin Reformatory Home, April 1, 1873, may be of interest. We are now roughly a century

from the reports of Dr. Rush and another century from our own era:

"Mr. _____ was a young man who commenced drinking in the Army. He was genial and social in his habits, and this one became so fixed that he was declared a hopeless case. He would absent himself from home and wander over the city, drinking constantly. He was brought to us in a state of *mania-potu* just after the House was opened, before organization was complete, and was removed before any moral influences could be brought to bear upon him. In three months he again fell, and a member of the Godwin Association hearing of it, had him brought back by the Association in a terrible condition. He was carefully nursed and cared for, and his attention fully aroused to the fact that he had nearly added his name to the list of victims of this fearful vice. He became an earnest reformed man, and is, and has been since July, a sober man, a consolation to his parents, and one of the most faithful and efficient workers in the Association."⁵⁹

(The Godwin Association was an organization of the graduates of the Franklin Reformatory Home, who assisted each other subsequent to their recovery. Hence the self-help impulse was still very active despite the passing of the Washingtonians.)

While the eventual fate of the American Association for the Cure of Inebriates is not known, it can be said that, if it did not survive as a group and failed to achieve any ultimate success in the establishment of separate treatment facilities, it nevertheless helped to keep that issue alive. Indeed in 1903 the Commonwealth of Pennsylvania passed an Inebriate Act which called for the commitment of a drunkard "to a proper hospital, or asylum, for restraint, care and treat-

ment."⁶⁰ Little was done, however; and in January of 1908 Dr. John Beans Carrell, a physician of Hatboro and a member of the Inebriate Hospital Committee of the State Medical Society, read a paper before the Philadelphia County Medical Society in complaint. No facility yet existed, and the inebriate was treated as either a criminal or insane. Dr. R. H. Chase of the Friend's Asylum for the Insane in Frankford is recorded as making the following statement, reminiscent of those in the 1870s:

"The institutions for the insane are not well adapted for the care and treatment of this class. The alcoholic resents as an insult his enforced association with the insane, and on the other hand the self-respecting insane person feels affronted that through the exigency of his misfortune he should be made to affiliate with members of a class whom he had hitherto regarded with more or less contempt. The mixture of the two elements seems to be as incompatible as the most rebellious chemical ingredients."⁶¹

In spite of the weight of this and other opinions and the sincere efforts of many persons to secure facilities for inebriates, once again little movement was evident. This was not merely the case in Pennsylvania. In 1917 Horatio Pollock and Edith Furbush surveyed the institutional management of inebriates and others in the United States for the National Committee for Mental Hygiene. They found⁶² that there were 571 institutions in the country as of January 1, 1917, for the management of the insane, the feeble-minded, epileptics and inebriates. Of these there were but four state institutions (Connecticut, Iowa, Massachusetts and Minnesota) and 28 private institutions for inebriates only.

Their census showed that a total of 4,891 inebriates were receiving institutional care in the United States at that time. This was by a very substantial margin the smallest of all of the four categories which were considered (Table II). Of the overall figure, 3,991 inebriates were in public institutions and 900 were in private institutions. The authors commented specifically that "the extent of private care of inebriates is also very meager.

In New Jersey 203 cases were reported in private institutions; in every other state the number was less than 100."

Such was the general situation on the eve of World War I. With respect to Pennsylvania, at least, there is little evidence that much of the significance was done regarding the public care of the alcoholic until after World War II. This does not mean that nothing whatever was done; many individuals no doubt put forth a sincere and determined effort, and it is regrettable that there is no way of acknowledging our particular debt to them. This period also saw the founding (1935) and rise of that remarkable organization, Alcoholics Anonymous, by all odds the single most important effort in the alcoholism treatment field ever mounted. Nevertheless the impression remains of a lack of substantial and organized effort, particularly of public and governmental effort.

A notable exception to this was Dr. Charles Dudley Saul (1880-1947), medical director of Saint Luke's and Children's Medical Center of Philadelphia from 1941 until his death. Dr. Saul had begun to treat alcoholism at the hospital as early as 1938. As a result, we are told (in a statement reminiscent of Drs. Parrish, Carrell, and others) that:

"he became convinced that the individualistic method was not adequate and began to plan a clinic where alcoholics might be separated from other sick people and given an opportunity to learn about their disease by discussion with fellow sufferers. The advent of the war, however, blocked any development of this plan until 1946."⁶³

The Saul Clinic finally opened on June 10, 1946, shortly before Dr. Saul's death. It was named in honor of the man "who boldly called our profession's attention to its responsibility in the treatment of alcoholism and stimulated the interest of physicians and psychiatrists."⁶⁴ The basic idea of the clinic, as described by its first medical superintendent, was to "give these individuals a sober moment to analyze their problem so that they can decide what they wish to do about it."⁶⁵ Hence, short-term rather than long-term hospital treatment was

TABLE III
Estimated Number of Substance Abusers Per 10,000 Adults, by Geographic Strata, Pennsylvania, 1973.
Calculated from Reference No. 43.

Stratum	Per 10,000 adults:	
	Est. No. Opiate Abusers	Est. No. Alcohol Abusers
Urban Counties	120	920
Suburban Counties	100	630
Small Cities	80	750
Rural Counties	70	540
Pennsylvania	92	734

stressed; in addition, there was a heavy emphasis upon medical management as well as interaction with Alcoholics Anonymous. Thirty-three patients were admitted in June and 48 in July,⁶⁶ while the total count between the opening of the unit and April 30, 1949, was 2,878 admissions.⁶⁷ Obviously, the Saul Clinic was a going concern. It still is.

Unfortunately, however, it stood alone at the time. In the year after the clinic was founded, a resolution was passed by the General Assembly of the Commonwealth directing the Joint State Government Commission to investigate the problem of alcoholism in Pennsylvania. A subcommittee was appointed which reviewed the existing literature, held a hearing, and visited the Saul Clinic. Despite the fact that there may have been as many as 58,000 alcoholics in Pennsylvania at that time, the only action which the state legislature had thus far taken was to provide \$50,000 over a two-year period for the Saul Clinic. The committee recommended that the biennial appropriation be continued and matched with a similar appropriation for Pittsburgh. The Department of Health was asked to develop a better statistical estimate of alcoholism. In an interesting turn of phrase it was "deemed inexpedient" to require medical and nursing schools to teach courses concerning alcoholism, though they were encouraged to do so. Likewise, hospitals were "encouraged" to admit alcoholics. In sum, it is rather a dreary record and the lack of legislative enthusiasm is all too evident.⁶⁸

With the advent of the Saul Clinic we have almost arrived in the present. Yet it is useful to look at a document

which appeared in 1959, some thirteen years later. *The Alcoholism Handbook and Directory of Facilities*, published by the Department of Public Health of the City of Philadelphia, listed all facilities in the five-county area of southeast Pennsylvania which were in use at the time for the treatment of alcoholism. Under the rubric "medical facilities primarily for alcoholism" we may find the sort of institutions under consideration here. At that time there were but five: the Malvern Institute, the Saul Clinic, Willow Grove Hospital, the Alcoholism Control Unit, an outpatient operation at 415 West Girard, and the Philadelphia Counselling Center for Alcoholism at 915 Corinthian. While some improvement in services had obviously occurred, the overall effort remained unimpressive, especially in view of the size of the population of the five-county area.⁶⁹

In more recent times an increased effort has been mounted in Pennsylvania to deal with the problem of the treatment of alcoholism. While much has been done, much remains to do. In addition to the many factors which have contributed to a lack of progress in the past, there is an entirely new factor impinging upon the development of alcoholism treatment. This is the impact of the treatment being provided to opiate abusers. It has not been important previously because the scope of the narcotic addiction treatment effort was minimal. But it now appears to be a factor of some significance and will be briefly considered. A more detailed presentation appears in a separate publication.⁷⁰

There can be little question that alcoholism is more prevalent than narcotic addiction. Table III presents

TABLE IV

Ratio of Available Treatment Slots to Number of Estimated Abusers,
Pennsylvania, 1973.
Calculated from Reference No. 43.

Treatment slots available for: Stratum	Opiate Abusers	Alcohol Abusers
Urban Counties	1: 7.6	1: 43.8
Suburban Counties	1: 9.1	1: 57.5
Small Cities	1:26.9	1:225.4
Rural Counties	1:77.1	1:155.2
Pennsylvania	1: 9.6	1:102.4

data drawn from the Schaps and Rubin study, which considered both problems. It shows that in Pennsylvania as a whole, as well as in each geographic stratum of the state, alcoholism is far more common. Now, if this were a strictly rational world, it would follow that treatment facilities would be provided according to the number of persons who suffer from an illness. Such is not the case. Table IV, taken from the same study, shows that exactly the opposite is true. Roughly speaking there is one treatment slot for every ten narcotic addicts and only one slot for every hundred alcoholics, in spite of the fact that there are about eight times as many alcoholics as addicts.

Thus in the field of addiction treat-

ment we have a paradox. Less treatment is available for the larger problem. It is not unique to this field.⁷¹ But it may be due to a unique cause. This is suggested by a graph (Figure 1) showing the establishment dates of alcoholism treatment programs considered in this study and comparing them with the establishment dates of narcotic addiction treatment programs considered in a previous study.⁷² The graph shows that, as the establishment of narcotic addiction treatment programs increased in the period after 1965, the establishment of alcoholism treatment programs decreased. The data suggest—though they do not prove—that there may be a causal relationship between these two phenomena. A version of

Gresham's Law may be operative in the addiction field. Treatment for narcotic addiction may tend to drive out treatment for alcoholism. Perhaps the converse is true as well. There are many possible explanations for this phenomenon but, in this age of inflation, the most persuasive may be the economic. A finite amount of capital is available for the treatment effort in both fields; hence, when one aspect captures the popular imagination it is differentially subsidized, and the other aspect suffers.

Logically, of course, this is unfortunate. Problems ought to be dealt with according to a rational ordering of priorities. This does not appear to be happening in the addiction field. With the advent of single state and federal agencies devoted to the addictions, and with the dawning of the belief that all citizens have a right to treatment for their health problems, including drug and alcohol abuse, there may finally come a time when there is an equitable distribution of treatment capability. But the historical odds against such an eventuality are obviously quite high.

In summary, mankind in general and Pennsylvanians in particular have had a long and troubled relationship with alcohol. They have also had a long and troublesome record of

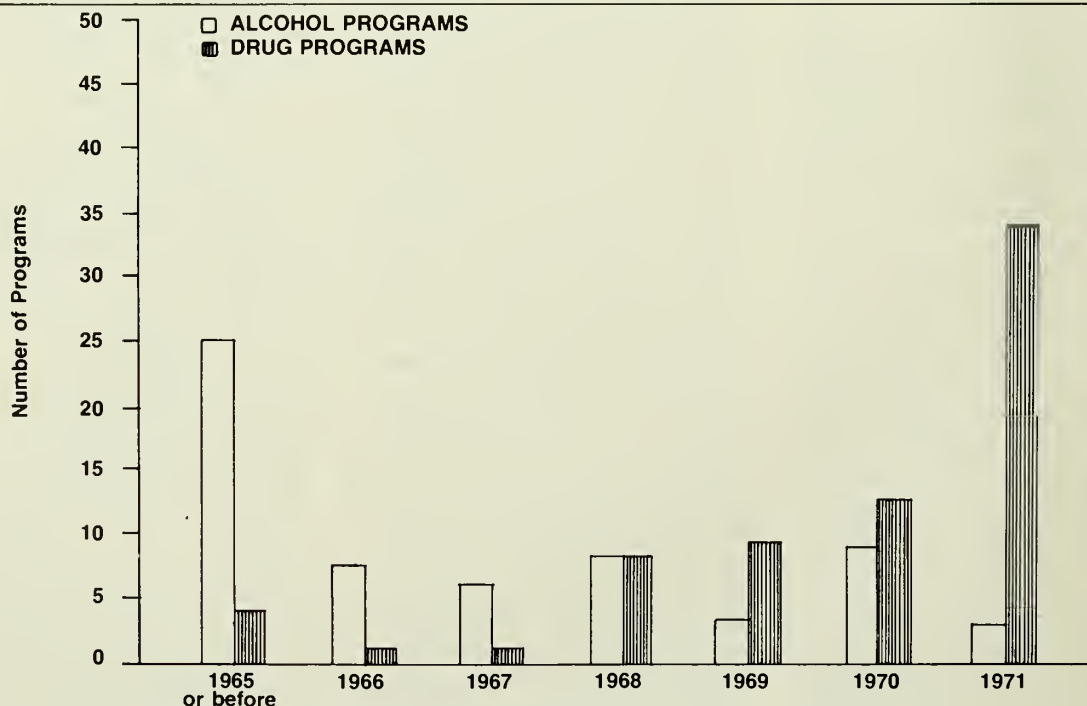


Figure 1. Establishment date of drug and alcohol programs in Pennsylvania

not providing adequately for problems due to alcoholism, even though the need for this has been clearly and consistently seen by at least a portion of the citizenry. Recently the added problem of dealing with a similar difficulty, narcotic addiction, may have had an adverse effect upon the overall alcoholism treatment effort. Despite many admirable attempts, the goal of adequate service has not yet been reached. □

REFERENCES

1. Tolles, F.B.; and Alderfer, E.G., (eds.). The Witness of William Penn. New York: The Macmillan Company, 1957. p. 173.
2. Collier, H.O.J. The concept of the quasi-abstinence effect and its use in the investigation of dependence mechanisms. *Pharm. 11*:58-61, 1974.
3. Roueche, B. The neutral spirit: A portrait of alcohol. Boston: Little, Brown & Company, 1960. p. 4.
4. Turnbull, G.H. Fruit of the vine: As seen by many witnesses of all times. Baltimore: Lord Baltimore Press, 1951. p. 103.
5. *Ibid.*, p. 107.
6. Mommsen, T. The history of Rome. Translator Anonymous. Glencoe, Illinois: The Free Press and The Falcon's Wing Press. n.d., vol. 4. p. 464.
7. Turnbull, *op. cit.*, pp. 123-24.
8. Housman, A.E. Epilogue. From A Shropshire lad.
9. Roueche, *op. cit.*, p. 21.
10. Kobler, J. Ardent spirits: The rise and fall of prohibition. New York: G.P. Putnam's Sons, 1973. p. 29.
11. Watson, J. Observations on the customary use of distilled spirituous liquors, particularly addressed to the Inhabitants of Pennsylvania of Denominations, and also to the People of the United States Generally. Philadelphia: Kimber & Conrad, 1810.
12. Krout, J.A. The origins of prohibition. New York: Alfred A. Knopf, 1925. p. 26.
13. Gusfield, J.R. Status conflicts and the changing ideologies of the American Temperance Movement. In: Pittman, J. and Snyder, C.R. (eds.): Society, culture, and drinking patterns. New York: John Wiley & Sons, 1962. p. 104.
14. Benson, E.A. (ed.). Penn Family recipes: Cooking recipes of William Penn's wife Gulielma. York, Pennsylvania: George Shumway, 1966. p. 40.
15. Baron, S. Brewed in America: A history of beer and ale in the United States. Boston: Little, Brown & Company, 1962. p. 45.
16. Krout, *op. cit.*, p. 31.
17. Benezet, A. The Mighty Destroyer Displayed, in some Account of the Dreadful Havock made by the mistaken Use as well as Abuse of DISTILLED SPIRITOUS LIQUORS, by a Lover of Mankind. Philadelphia: Joseph Cruikshank, 1774. p. 21.
18. Krout, *op. cit.*, p. 37.
19. *Ibid.*, p. 12.
20. Mittelberger, G. Journey to Pennsylvania. Edited and translated by O. Handlin and J. Clive. Cambridge: The Belknap Press, 1960. pp. 50-51.
21. Popham, R.E.; Schmidt, W.; and deLint, J. The prevention of alcoholism: epidemiological studies of the effects of government control measures. Manuscript. To be published in: Ewing, J.A. and Rouse, B.A. (eds.): Law and drinking behavior. Chapel Hill: University of North Carolina Press. See esp. pp. 10-12.
22. Schmidt, W.; and Bronetto, J. Death from liver cirrhosis and specific alcoholic beverage consumption: an ecological study. *Am. J. Pub. Health*, 52:1473-82 (Sept.) 1962.
23. Benezet, *op. cit.*, p. 4.
24. *Ibid.*, p. 12.
25. Popham, et al., *op. cit.*
26. Benezet, *op. cit.*, pp. 43-44.
27. Rush, B. An inquiry into the effects of ardent spirits upon the human body and mind, with an account of the means of preventing and the remedies for curing them. First published in 1785. Brookfield: E. Merriam & Company, 1814 (Eighth Edition). Reprinted in J. Studies on Alcohol, 4: 321-41, September 1943.
28. Brown, J.H. Early American beverages. Rutland: Charles E. Tuttle, 1966. p. 140.
29. Cutler, W.G. The nation's first rebellion. *Magazine of American History*, 12: 332-47, 1884. p. 334.
30. Wiley, Richard T. The Whiskey Insurrection: A General View. Elizabeth, Pennsylvania: Herald Printing House, 1912. p. 15.
31. *Ibid.*, p. 19.
32. *Ibid.*, p. 30.
33. *Ibid.*, p. 6.
34. *Ibid.*, p. 46.
35. Cutler, *op. cit.*, p. 346.
36. Wiley, *op. cit.*, p. 6.
37. Kobler, *op. cit.*
38. Krout, *op. cit.*
39. Wine Marketing Handbook. New York: Gavin-Jobson Associates, 1974.
40. The Liquor Handbook. New York: Gavin-Jobson Associates, 1973.
41. The Brewer's Almanac. Washington: United States Brewers' Association, 1972.
42. Baron, *op. cit.*, p. 176.
43. Barrett, M. The Pennsylvania State Alcohol Abuse and Alcoholism Plan for 1971-72. Harrisburg: Commonwealth of Pennsylvania, 1972, vol. I. A design for action, p. 25. Exhibit I.
44. Schaps, E.; and Rubin, E.L. A study of prevalence and intensity of drug and alcohol use in the Commonwealth of Pennsylvania. Harrisburg: Governor's Council on Drug and Alcohol Abuse, August 10, 1973.
45. Cahalan, D. Problem Drinkers. San Francisco: Jossey-Bass, 1970. p. 36.
46. deLint, J.; and Schmidt, W. The epidemiology of alcoholism. In: Biological basis of alcoholism, ed. Y. Israel and J. Mardones. New York: Wiley, 1971. pp. 423-42.
47. Maxwell, M.A. The Washingtonian Movement. *J. Studies on Alcohol*, 11: 410-51, 1950. p. 432.
48. *Ibid.*, pp. 411-12.
49. Glaser, F. B. Some Historical Aspects of the Drug-Free Therapeutic Community. *Am. J. Drug and Alcohol Abuse*, 1: 37-52 (May) 1974.
50. Maxwell, *op. cit.*, p. 419.
51. *Ibid.*, p. 421.
52. *Ibid.*, p. 423.
53. Kobler, *op. cit.*, pp. 180-83 ff.
54. Harris, R.P. Untitled volume of bound reports, bearing in pencil the name of Dr. R. P. Harris. Privately bound, no publisher. Library of the College of Physicians of Philadelphia. 6P/15.
55. Parrish, J. Annual Address before the American Association for the Cure of Inebriates by J. Parrish, M.D., President, September 28, 1875.
56. Parrish, J. and 22 others. Address to the people by the Directors, Pennsylvania Sanitarium. Philadelphia: Henry B. Ashmead, 1871. p. 15.
57. *Ibid.*, p. 11.
58. Harris, *op. cit.*
59. *Ibid.*
60. Carrell, J.B. Why Pennsylvania should build, equip and maintain a hospital for the restraint, care, and treatment of inebriates, and what the hospital should be. *Pa. Med. J.*, 11: 628-36, 1908. pp. 628-29.
61. *Ibid.*, p. 631.
62. Pollock, H.M.; and Furbush, E.M. Insane, feeble-minded, epileptics and inebriates in institutions in the United States, January 1, 1917. *Mental Hygiene*, vol. 1, no. 4, October 1917. Pagination not given.
63. Studies in alcoholism: A report on the work of the C. Dudley Saul clinic, 1946-49. Published by the Board of Trustees of St. Luke's and Children's Medical Center, September 1949. p. 1.
64. Davis, C.N. Experience in short term hospitalization of the alcoholic. *J. Studies on Alcohol*, 8:55-60, 1947. p. 55.
65. *Ibid.*, p. 59.
66. *Ibid.*, pp. 59-60.
67. Studies in Alcoholism, p. 9.
68. Brunner, C.H., Jr. Alcoholism: A report of the Joint State Government Commission to the General Assembly of the Commonwealth of Pennsylvania. December 1948.
69. Linden, M.E. Alcoholism handbook and directory of facilities. Published by the Division of Mental Health, Public Health Services, Department of Public Health, City of Philadelphia, 1959. pp. 43-50.
70. Glaser, F.B.; and Greenberg, S.W. Relationship between treatment facilities and prevalence of alcoholism and drug abuse. *J. Studies on Alcohol*, 36 (3): 348-358, March 1975.
71. Kunitz, S.J. Some notes on physiologic conditions as social problems. *Soc. Sci. Med.*, 8: 207-11, April 1974.
72. Adler, F.; Moffett, A.D.; Glaser, F.B.; Bail, J.C.; and Horvitz, D. A systems approach to drug abuse treatment. Philadelphia: Dorrance and Company, 1974.



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REPORT OF CONTINUING MEDICAL EDUCATION (continued)

Sponsor: Institution, or Publication, or Physician, or Self	Location City State	Description of Learning Activity (Course, paper, journal, self-assessment prgm., etc.)	Dates of Attendance (inclusive)	Hours of Study	TOTALS
Brought Forward from Previous Page: Total number of hours spent in Category 1 activities: _____					
CATEGORY 2: C.M.E. Activities with Non-accredited Sponsorship (There is a limit of 45 credit hours here.)					
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
Total number of hours spent in Category 2 activities:				_____	_____
CATEGORY 3: Medical Teaching (There is a limit of 45 credit hours for this category.)					
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
Total number of hours spent in Category 3 activities:				_____	_____
Category 4: Papers, Publications, Books and Exhibits (There is a 40 credit hour limit for this category.)					
_____	_____	_____	_____	_____	_____
Total number of hours spent in Category 4 activities:				_____	_____
CATEGORY 5: Non-supervised Individual C.M.E. Activities (There is a limit of 45 credit hours for this category. Not more than 22 credit hours may be claimed in any one subcategory.)					
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
Total number of hours spent in Category 5 activities:				_____	_____
CATEGORY 6: Other Meritorious Learning Experiences (There is a 45 credit hour limit. Attach description)					
Total number of hours spent in Category 6 activities:				_____	_____

TOTAL CREDIT HOURS - Completed During the Three Year Qualifying Period Immediately Preceding _____

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Medical Education Number: _____

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Signature: _____

Official Call to the 1976 Annual Session

Pennsylvania Medical Society House of Delegates

The 1976 Annual Session of the House of Delegates of the Pennsylvania Medical Society will convene in the Grand Ballroom of the Bellevue-Stratford Hotel, Philadelphia, Pennsylvania, Thursday, September 16, 1976, at 1:00 p.m. The second session of the House of Delegates is scheduled for Friday, September 16, 1976 in the Grand Ballroom beginning at 1:00 p.m. The third and concluding session of the House will be held Saturday, September 17, 1976 in the Grand Ballroom beginning at 9:30 a.m.

Elections

Nominations and/or elections will be held at the second session, Friday afternoon, September 17, 1976, as called for in Standing Rule No. 1 of the House of Delegates. Among the general officers to be elected by the 1976 House of Delegates will be: a Vice President, a Secretary, a Speaker of the House of Delegates, and a Vice Speaker of the House of Delegates. Also to be elected are a Trustee and Councilor for the Second Councilor District, to serve five years to succeed Leroy A. Gehris, M.D., Berks County, who is eligible for re-election; a Trustee and Councilor for the Eighth Councilor District to serve for five years to succeed David J. Keck, M.D., Erie County, who is eligible for re-election; a Trustee and Councilor for the Eleventh Councilor District to succeed William C. Ryan, M.D., Somerset County, who is eligible for re-election.

Also to be elected for a two-year term beginning January 1, 1977, will be six delegates and six alternates to the American Medical Association. Delegates whose terms expire December 31, 1976, are: R. William Alexander, M.D., Berks County; Raymond C. Grandon, M.D., Dauphin County; Edmund L. Housel, M.D., Philadelphia County; William J. Kelly, M.D., Allegheny County; William Y. Rial, M.D., Delaware County; George A. Rowland, M.D., Columbia County.

Alternate Delegates whose terms expire December 31, 1976, are: Harry V. Armitage, M.D., Delaware County; Robert J. Carroll, M.D., Allegheny County; James B. Donaldson, M.D., Philadelphia County; Loraine H. Erhard, M.D., Clearfield County; Richard L. Huber, M.D., Lackawanna County; R. Robert Tyson, M.D., Philadelphia County.

As directed by Chapter XIV, Section 2(e) of the Bylaws, the Committee to Nominate Delegates and Alternates to the AMA makes the following nominations for delegates for two-year terms commencing January 1, 1977:

1. R. William Alexander, M.D. (Berks County)
2. Raymond C. Grandon, M.D. (Dauphin County)
3. Edmund L. Housel, M.D. (Philadelphia County)

4. William J. Kelly, M.D. (Allegheny County)
5. William Y. Rial, M.D. (Delaware County)
6. George A. Rowland, M.D. (Columbia County)

The Committee makes the following eight nominations for six alternate delegates for two-year terms commencing January 1, 1977:

1. Harry V. Armitage, M.D. (Delaware County)
2. Donald C. Brown, M.D. (Westmoreland County)
3. Robert J. Carroll, M.D. (Allegheny County)
4. Joseph N. Demko, M.D. (Lackawanna County)
5. James B. Donaldson, M.D. (Philadelphia County)
6. Charles Heisterkamp, III, M.D. (Lancaster County)
7. William D. Lamberton, M.D. (Erie County)
8. R. Robert Tyson, M.D. (Philadelphia County)

Also to be elected will be two members to serve on the Committee to Nominate Delegates and Alternates to the American Medical Association. One election is required to fill the position of John G. Hallisey, M.D., Beaver County, whose term expires and who is eligible for a second three-year term. The second election is required to fill the position of John L. Steigerwalt, M.D., Montgomery County, whose term expires and who is not eligible for re-election.

Also to be elected is a District Censor from each component medical society to serve for one year following the close of the 1976 House of Delegates session.

The component county medical societies have submitted the following nominations for District Censor:

Adams, **James H. Allison**; Allegheny, **William D. Stewart**; Armstrong, ; Beaver, **John G. Hallisey**; Bedford, **Philip C. Grana**; Berks, **Brian A. Wummer**; Blair, ; Bradford, ; Bucks, **Stanley F. Peters**; Butler, **Robert C. McCorry**; Cambria, **Warren F. White**; Carbon, ; Centre, **H. Richard Ishler**; Chester, ; Clarion, ; Clearfield, ; Clinton, **George J. Treires**; Columbia, **James F. Youngkin**; Crawford, **David D. Kirkpatrick, Jr.**; Cumberland, **Hans S. Roe**; Dauphin, **Robert P. Dutlinger**; Delaware, **Richard W. Garlich**; Elk-Cameron, **Robert J. Dickinson**; Erie, **Robert L. Loeb**; Fayette, **Veronica Binns**; Franklin, **Albert W. Freeman**; Greene, **David L. Avner**; Huntingdon, ; Indiana, **Ralph F. Waldo**; Jefferson, **Nicholas F. Lorenzo**; Lackawanna, **Norman S. Berger**; Lancaster, **William G. Phippen**; Lawrence, ; Lebanon, **C. Ray Bell**; Lehigh, **Frederick A. Dry**; Luzerne, **Samuel T. Buckman**; Lycoming, **Franklin G. Wade**; McKean, **Bruno P. Sicher**; Mercer, **Anderson W. Donan**; Mifflin-Juniata, **Donald E. Basom**; Monroe, **Claus G. Jordan**; Montgomery, **Rudolph K. Glocker**; Montour, **William O. Curry**; Northampton, **Walter J. Filipek**; Northumberland, **J. Mestyn Davis**; Perry, **James O. Rumbaugh, Jr.**; Philadelphia,

Charles M. Thompson; Potter, Francisco B. Villa; Schuylkill, Gabriel M. Lizak; Somerset, ; Susquehanna, Michael Markarian; Tioga, ; Union, Joseph Weightman; Venango, Kenneth H. Heasley; Warren, Donald J. Furman; Washington, John C. McGinnis; Wayne-Pike, Howard R. Patton; Westmoreland, Leslie S. Pierce; Wyoming, John S. Rinehimer, Jr.; York, Donald R. Gross.

Proposed Amendments to the Constitution and Bylaws

Printed below is the text of the amendments to the Constitution and Bylaws which are being proposed by the Committee on Constitution and Bylaws.*

*Material underlined is being added. Material in brackets is being deleted.

Subject One

I. Unified membership in county, state, and national medical societies.

Constitution

Article IV - Membership

Section 2. Active Members. The Active Members of this Society shall be physicians who are members of the Component Societies and the American Medical Association.

(Secretary's Note: *Two-thirds vote required.*)

Bylaws

Chapter I - Membership

Section 2. Membership Compulsory. Every member of a Component Society eligible for membership in this Society as provided in Article IV of the Constitution shall become a member of this Society and the American Medical Association within three months after his election to any class of membership therein, unless such member is a provisional or honorary member of the component Society, in which event he shall not be required to become a member of this Society until three months after his election to some other class of membership.

(Secretary's Note: *Three-fourths vote required.*)

Subject Two

II. Term of suspension for those not meeting continuing education requirement

Bylaws

Chapter I—Membership

Section 6—Suspension from Membership. The membership of a member in this Society shall be suspended (a) on December 31 of any year (beginning in 1976) if he is an Active or Senior-Active dues-paying or Associate member who has failed to qualify for the American Medical Association's Physician's Recognition Award provided the Office of the Executive Vice President has given such member sixty days notice prior to December 31, and such suspension shall [be for a period of one year.] remain in force until such member submits sufficient supplemental records to fulfill the award requirement. (b) upon suspension of his membership in his Component Society, and (c)

upon the effective date, as provided in Section 7 of Chapter XIII of these Bylaws, of an order to that effect issued by the Judicial Council of this Society. The suspended member shall not be entitled to exercise any of the rights and privileges of membership during the period of suspension, shall be required to continue the payment of annual assessments without any reduction whatsoever, and shall be restored to full membership upon the expiration of the period of suspension provided he has qualified for a current AMA Physician's Award Certificate.

Section 7. Termination of Membership. The membership of a member of this Society shall terminate (a) in the case of Active or Senior Active or Associate Members suspended pursuant to subsection (a) of Section 6 of this Chapter who have not completed the continuing medical education requirement for the AMA Physician's Recognition Award by the end of [the] a one-year period of suspension. (b) upon (i) termination of his membership in his Component Society for any reason whatsoever, or (ii) failure to pay a delinquent assessment within thirty days after notice of such delinquency as provided in Section 2 of Chapter IX of these Bylaws, or (iii) three months after ceasing to be eligible for membership herein in the class of membership in which he is a member as specified in the Constitution, unless at such time an application or certification for another class of membership for which the member will become immediately eligible is pending in the office of the Executive Vice President of this Society, and (c) upon the effective date, as provided in Section 7 of Chapter XIII of these Bylaws, of an order to that effect issued by the Judicial Council of this Society. Any person whose membership has been terminated for failure to pay a delinquent assessment shall be reinstated to membership without any break in continuity of membership upon payment of the delinquent assessment in full before December 31 of the assessment year and reinstatement by his Component Society, but no such member under any circumstances shall be considered to be an Active, Senior Active, Intern or Resident member in good standing during the period between January 1 of the year for which assessment was delinquent and the date of reinstatement for the purposes of any section of the Constitution or these Bylaws. Any Active or Senior Active dues-paying or Associate member whose membership has been terminated by reason of failure to meet the requirements for the AMA Physician's Recognition Award shall be reinstated to membership if, after meeting all the other requirements for reinstatement, he submits evidence that he has met all the requirements for such award for a current period and that at least one-third of the hours required were obtained during the current calendar year.

(Secretary's Note: *Three-fourths vote required.*)

Subject Three

III. Possible Change in Qualifications for Affiliate Member Status.

Constitution

Article IV. Membership

Section 6. Affiliate Member. Upon recommendation and certification in due form by the Component Society to and election by the Board of Trustees and Councilors, any

member of the Component Society not engaged in active practice within the jurisdiction of the Component Society, may be made an Affiliate Member of this Society and remain as such provided he is a person who belongs to one of the following classes: (a) persons who are members of national medical societies of foreign countries; (b) American physicians, whether or not licensed to practice medicine and surgery in the Commonwealth, engaged in missionary or philanthropic labors; (c) full-time teachers of medicine or of the art and sciences allied to medicine who are not holders of an unrestricted license to practice medicine and surgery in the Commonwealth of Pennsylvania; (d) physicians not fully licensed to practice medicine in Pennsylvania who are engaged in Pennsylvania in research, [public health,] or administrative medicine; (e) physicians, whether or not fully licensed to practice medicine in Pennsylvania, who are retired from active practice, and (f) physicians in active practice who move out of the Commonwealth provided they concurrently maintain active membership in a county medical society and the state medical society in their new state of residence. Such out-of-state affiliate members shall not be eligible to participate in insurance programs endorsed by the Pennsylvania Medical Society. Affiliate Members shall not be required to pay any annual assessment.

Election to Affiliate Membership pursuant to part (b) above shall not be interpreted as breaking the continuous Active Membership of an Active Member so as to make him ineligible for Senior Active Membership or Associate Membership under Section 3 and 4 respectively of this Article IV.

(Secretary's Note: Two-thirds vote required.)

Subject Four

IV. Clarification of Membership on Councils and Committees

Bylaws

Chapter XIV. Committees, Administrative Councils and Commissions

Section 1. (d iii) Qualification for Membership on Committees, Administrative Councils and Commissions.

[No member shall serve concurrently as (a) member of more than one administrative council or commission, or (b) a member of more than one commission and one standing committee, or (c) as an appointed member of more than two standing committees.] A member may serve concurrently only as (a) a member of one administrative council and one commission under that council, or (b) a member of one council or one commission and one standing committee, or (c) as an appointed member of not more than two standing committees.

(Secretary's Note: Three-quarters vote required.)

Subject Five

V. Revised Time Limits for Special Sessions of the House of Delegates.

Constitution

Article VII—Sessions and Assemblies

Section 2. Special Sessions. Special sessions, either of

this Society or of the House of Delegates, may be requested at any time by (a) nine members of the Board of Trustees and Councilors, or (b) forty voting members of the House of Delegates, or (c) two hundred Active, Senior Active, Intern and/or Resident Members of this Society, provided such special session has the approval of the Component Society or Societies having an aggregate membership of at least 200 physicians for the transaction of such business as is proper and set forth in the request for call. Such request shall be in writing and delivered to the Secretary, and thereupon the Secretary shall fix the time and place for the session, which shall be not less than [forty] fourteen and not more than ninety days after receipt of the request, and shall call the session by appropriate notice, which shall state the purpose and shall be made in the manner provided in Section 1 of this Article VII except that the original call shall be issued no later than [thirty] fourteen days prior to the holding of the session.

(Secretary's Note: Two-thirds vote required.)

Subject Six

VI. Possible Disciplinary Amendments

Bylaws

Chapter XIII—Disciplinary Proceedings and Appeals

Section 4. Appeals to District Boards of Censors.

Any member of a Component Society who has been censured, suspended or expelled thereby and any physician who has been refused membership by the Component Society or any Component Society aggrieved by the decision of another Component Society's Board of Censors shall have the right of appeal to the District Board of Censors for that Councilor District, provided that (a) written notice of the appeal is given to the Councilor of the Councilor District within sixty days after the censure, suspension, expulsion, or notice of rejection of an application for membership, as the case may be, and in this latter connection the failure of a Component Society to accept or reject an application for membership within six months after the filing thereof shall automatically be deemed to constitute a rejection at the end of said six months period, and (b) a brief, outlining the basis of such appeal, is presented to said Councilor within ninety days after either of the events heretofore mentioned.

(Secretary's Note: Three-quarters vote required.)

Subject Seven

VII. Expulsion of Unqualified Witness.

Bylaws

Chapter XIII—Disciplinary Proceedings and Appeals

Section 10. Expulsion of Unqualified Witness.

Any member of this Society who testifies as an expert witness without meeting the qualifications set forth in this Section shall be subject to expulsion after a due process hearing as set forth in this Chapter. An expert witness must have basic educational and professional knowledge as a general foundation for his testimony, and in addition, has current personal experience and practical familiarity with the problems that are being considered and is actively engaged in the practice of the medical subject under discussion.

(Secretary's Note: Three-quarters vote required.)

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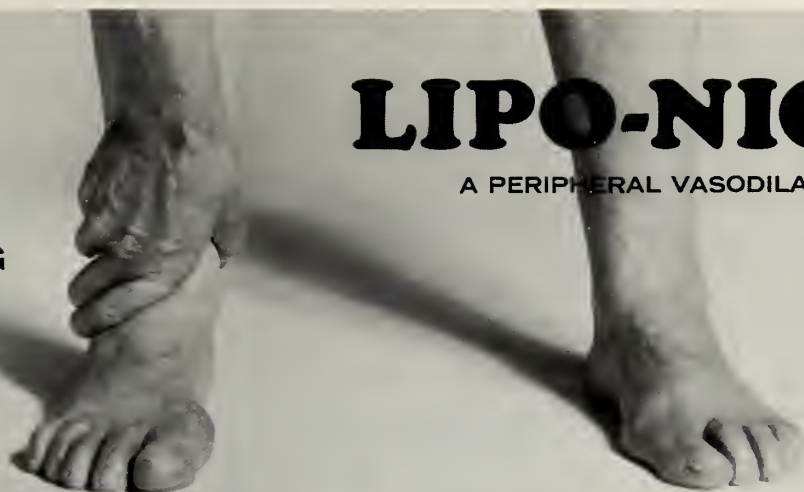
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Willard A. Krehl, M.D., recently became a member of President Gerald R. Ford's panel on the scientific and social aspects of nutrition. Dr. Krehl, chairman of community health and preventive medicine at Jefferson Medical College, Thomas Jefferson University, is a past president of the American Society for Clinical Nutrition and former editor in chief of the *American Journal of Clinical Nutrition*.



DR. KREHL



DR. NEWMAN

Julius Newman, M.D., Penn Valley, was recently named chairman of the newly formed department of facial plastic and reconstructive surgery at Haverford General Hospital, Haverford. Dr. Newman is founder and immediate past president of the Philadelphia Society of Facial Plastic Surgeons, and a fellow of the American Academy of Facial and Reconstructive Surgery and the International Society of Cosmetic Surgeons.

Lee Arnall Malit, M.D., was recently appointed assistant professor of anesthesiology in The Milton S. Eshley Medical Center, The Pennsylvania State University. Previously he was a clinical associate in anesthesiology at the National Institutes of Health.

Bruce W. Jafek, M.D., was recently appointed professor and chairman of the department of otolaryngology at the University of Colorado Medical Center, Denver. He was formerly assistant professor in the department of otolaryngology and human communication at the University of Pennsylvania, and has served as chairman of the department and medical director at the Graduate Hospital of the University of Pennsylvania.

Pennsylvania Secretary of Health **Leonard Bachman, M.D.**, recently delivered the fourth annual Monheim lecture at the University of Pittsburgh Graduate School of Public Health. In his speech he said that instead of spending millions of dollars on technological life sustaining devices, physicians should increase compassion and care for the terminally ill and the nation should emphasize preventive medicine. A new health strategy should address: equity of access to the health system as well as housing, nutrition, recreation, and education; an examination of all public policy which impacts on the health of people; and an expanded effort to enhance the individual's own responsibility for his health and his health care.

The Medical College of Pennsylvania has developed a new program to provide psychological and guidance services to children in the nonpublic, nonprofit schools. The program is to be administered by the college's child psychiatry section under the leadership of recently appointed **Selma Kramer, M.D.** Dr. Kramer is professor and chief of the section. She is a past president of the Philadelphia Psychoanalytic Society and the Philadelphia Psychoanalytical Institute, assistant editor of the *Journal of the American Psychoanalytic Association* and chairman of the child analysis committee of the American Psychoanalytical Institute.

M. Leon Skolnick, M.D., was recently appointed associate professor of radiology at the University Health Center of Pittsburgh. Dr. Skolnick is a member of the faculty of the University of Pittsburgh School of Medicine and director of Ultrasound Laboratories at Presbyterian-University Hospital.

Charles Saul August, M.D., Wynnewood, recently became director of the newly established bone marrow program at the Children's Hospital of Philadelphia. Children's Hospital was

designated a pediatric cancer research and treatment center under the President's Conquest of Cancer Act in 1972. The hospital is treating about 400 children with cancer, a third of whom suffer from leukemia. Dr. August is an associate professor of pediatrics, division of oncology and immunology, at the University of Pennsylvania School of Medicine.

The Exchange Club of Oil City recently chose **Thomas Thomas, M.D.**, to receive the 27th annual Golden Deed Award. Dr. Thomas was chosen for outstanding work and contributions toward the betterment of the community.

Frans Vossenberg, M.D., Wayne, was recently appointed head of the medical staff at Sacred Heart Hospital, Allentown. He has been with the hospital since 1959.

The American Board of Gastroenterology recently certified **Leon A. Rigberg, M.D.**, in gastroenterology. He is on the staff of St. Luke's Hospital, Allentown.

Residents of Wampum paid tribute recently to **Gerald Zieve, M.D.**, who retired after 40 years of service as a general practitioner in the area. About 300 area residents attended a testimonial dinner held in Dr. Zieve's honor.

Dorothea M. Gilmore, M.D., Clearfield, recently received the State Society award for 50 years of service in medicine during a dinner meeting of the Clearfield County Medical Society. Dr. Gilmore spent 45 of the 50 years with the Clearfield Hospital, where she is an associate pathologist.

George Manstein, M.D., Philadelphia, was recently elected an honorary fellow of the Israel Association of Plastic Surgeons for his work at the Shaare Zedek and Hadassah Hospitals in Jerusalem since 1967. Dr. Manstein is chairman, plastic surgery department, Albert Einstein Medical

Center, and assistant professor of plastic surgery for Temple University School of Medicine.

Albert J. Finestone, M.D., F.A.C.P., received the Man of the Year Award from Temple University School of Medicine at the school's annual founder's dinner. Dr. Finestone is clinical professor of medicine and assistant dean of continuing medical education at the school of medicine.

Richard C. Lyons, M.D., Erie, became president of the Mayo Urologic Alumni Association during a recent meeting of the group in Las Vegas. Dr. Lyons is associated with the department of urology in the Erie Clinic.

Jean T. Messner, M.D., was appointed recently as director of pediatric anesthesia services at The Milton S. Hershey Medical Center. She is an associate professor of anesthesiology in The Pennsylvania State University College of Medicine.

The Nicholson Women's Club recently sponsored a testimonial dinner for **William M. Alexander, M.D.**, in honor of his 42 years of service to the community. Dr. Alexander is on the medical staffs of the Moses Taylor and Community Medical Center Hospitals.

F. Budd Schooley, M.D., Dallas, recently announced publication of his new book, *Spiritual Traveler*, containing historical photos and news stories as well as more recent items from Dr. Schooley's area. Profits from the sale of the book will benefit the library building fund of the College Misericordia.

The American Board of Pediatrics recently certified **Bhupinder K. Varma, M.D.**, director of education and associate pediatrician at Harrisburg Hospital. Dr. Varma is a clinical assistant professor of pediatrics in the Pennsylvania State University College of Medicine, Hershey.

Robert K. Nielsen, M.D., was recently selected to receive a 1976 Mead Johnson Award for Graduate Training in Family Practice. Dr. Nielsen is a resident in family and community medicine at the Milton S. Hershey Medical Center, Hershey.

The Governor's Task Force on Arthritis recently held their first meeting in Elizabethtown. Physicians serving on the task force are the following: **Drs. Joseph L. Hollander, Warren A. Katz, John L. Sharboro, Philip R. Trommer, and Peter Vanance**, of Philadelphia; **Randolph C. Blodgett, Jr.**, Danville; **David Bronstein**, Harrisburg; **Nathan Sussman**, Camp Hill; **Carl Eisenbeis**, Pittsburgh; and **H. M. Margolis**, Pittsburgh.



DR. COX



DR. DeBLASIO

Paul A. Cox, M.D., Carlisle, recently became president of the Pennsylvania Academy of Ophthalmology and Otolaryngology during the organization's thirty-second annual convention and scientific meetings in Bedford.

Dr. Cox is a past president of the Cumberland County Medical Society, the Reading Eye, Ear, Nose, and Throat Society, and the Carlisle Hospital Medical Staff, and is a member of the State Society's Council on Governmental Relations.

President elect is Silvio H. DeBlasio, M.D., Natrona Heights. Dr. DeBlasio is chief of otolaryngology and senior staff member at Allegheny Valley Hospital.

Other officers are the following: Joseph C. Flanagan, M.D., Upper Darby, first vice president; Donald P. Vrabec, M.D., Danville, second vice president; Donald B. Kameron, M.D., Pittsburgh, secretary; William K. Grove, M.D., York, treasurer; and Donald T. Burns, M.D., Wyomissing, secretary for instruction.

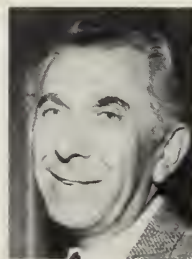
Elected to three-year terms as directors were: Eugene N. Myers, M.D., Pittsburgh, James B. Snow, Jr., M.D., Philadelphia, and Kenneth H. Messner, M.D., Hershey. Jerome Dersh, M.D., Reading, was re-elected as editor of the TRANS-ACTIONS.

George L. Jackson, M.D., recently became a governor of the Eastern Pennsylvania Region of the American College of Physicians. Dr. Jackson is director of nuclear medicine at Harrisburg Hospital, a member of the board of regents for the American College of Nuclear Physicians, and was the first president of the Pennsylvania College of Nuclear Medicine.

Jack D. Myers, M.D., was recently installed as president of the American College of Physicians during a meeting of the group in Philadelphia. Formerly chairman of the department of medicine in the University of Pittsburgh School of Medicine, he is currently a professor of medicine at the Pitt medical school.

Thomas L. Leaman, M.D., was recently elected vice president of the Society of Teachers of Family Medicine. Dr. Leaman is professor and chairman of family and community medicine at the Milton S. Hershey Medical Center, Hershey.

Clinton T. Sachs, M.D., Upper Darby, was recently promoted to clinical psychiatrist in chief for inpatient services of the Community Mental Health/Mental Retardation Programs at the Philadelphia Psychiatric Center (PPC). A senior staff psychiatrist, Dr. Sachs will continue to serve outpatients at the PPC Coping Clinic.



DR. SACHS



DR. BUNDY

Merle Bundy, M.D., Pittsburgh, received the 1976 Meritorious Service Award of the American Occupational Medical Association during the organization's annual meeting in Cincinnati. He was awarded for many years of leadership and service in the field. He is director of industrial medicine for the United States Steel Corporation and clinical assistant professor of occupational medicine for the University of Pittsburgh Graduate School of Public Health.



new members

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 Donald W. Spigner, M.D., Family Practice, 1821 Fulton St., Harrisburg 17102

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 Joseph K. Eshleman, D.O., Physical Medicine/Rehabilitation, 8124 Lindbergh Blvd., Philadelphia 19153
 Louis J. Freedman, M.D., Obstetrics and Gynecology, 210 Locust St., #126, Philadelphia 19106

Harry D. Getz, D.O., Pediatrics, 8201 Henry Ave., #621, Philadelphia 19128
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 Mitchell Horenstein, D.O., Family Practice, 7131 Ridge Ave., Philadelphia 19128
 Gary R. Horowitz, D.O., Neurology, Ste., W1805, Park Towne Pl., Philadelphia 19130
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 Peter J. Savino, M.D., Ophthalmology, 130 Spruce St., Philadelphia 19106
 Charles R. Schleifer, M.D., Radiology, 1429 Bittersweet Dr., Blackwood, NJ 08012
 John T. Smallwood, M.D., Internal Medicine, 885 N. Easton Rd., #1B1, Glenside 19038
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Emergency Room Physician—New 204 bed general hospital, in Western Pennsylvania 55 miles north of Pittsburgh. Full time position. Hourly rate plus liability, life, health, workmen's compensation, unemployment

compensation, retirement, holidays, vacation, salary continuation for sickness or disability. Pennsylvania license required. Fishing, hunting, and other recreational opportunities on unpolluted Allegheny River. Contact Robert L. Engel, Administrator. (412) 542-5404.

Physicians—\$45,000 per annum, excellent fringe benefits, regular hours. Stimulating medical careers in emergency and critical care medicine. Send resume to: Wayne M. Bailey, Administrative Director, Critical Care, 724 S. Edisto Ave., Columbia, SC 29205.

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Anesthesiologist—Needed in College town with drawing population of 25,000 located at intersection of I-79 and I-80. Growing area, clean air, good schools in Western Pennsylvania. All foreign graduates must have a permanent immigrant visa. Guarantee negotiable. Contact: Mr. J. A. Colaizzi, Administrator, Grove City Hospital, Grove City, PA 16127; Phone (412) 458-7132.

Physicians—Local and East Coast opportunities in all specialties including E.R., Family Practice, Internist and Psychiatry. For specific information contact The Health and Science Center, 1930 Chestnut St., Suite 2102, Philadelphia, PA 19103; telephone (215) 567-5680.

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FP/GP For Innovative Family Health Center in North Central Pennsylvania. To join 4 family practice general practice physicians, 2 dentists, and a psychiatrist in providing comprehensive primary health care. Excellent salary and fringe. Teaching opportunity in FP residency. Rural area with convenient cultural and outdoor activities. J.W. Montague, M.D., Medical Director, North Penn Family Health Center, Blossburg, PA 16912.

General Surgeon—Needed in College town with drawing population of 25,000 located at intersection of I-79 and I-80. Growing area, clean air, good schools in Western Pa. All foreign graduates must have a permanent visa. Guarantee negotiable. Contact: Mr. J. A. Colaizzi, Administrator, Grove City Hospital, Grove City, PA 16127; phone (412) 458-7132.

Internist for Innovative Family Health Center in north central Pennsylvania. To assure continuity of patient care by providing in-patient services in community hospital in conjunction with 5 family practice physicians, 2 dentists,

and a psychiatrist in providing comprehensive primary health care. Excellent salary and fringe. Teaching opportunity in FP residency. Rural area with convenient cultural and outdoor activities. J. W. Montague, M.D., Medical Director, North Penn Family Health Center, Blossburg, PA 16912.

House Staff Physician—Excellent opportunity for a Pennsylvania licensed physician to serve in a responsible position of a modern suburban 286 bed hospital accredited by the JCAH. \$30,000 per year plus many attractive fringe benefits including vacation, sick leave, paid pension plan, hospitalization, malpractice insurance, life insurance, and disability insurance. Excellent location-suburban Philadelphia. Call collect or write T. A. Harrington, Administrator, Holy Redeemer Hospital, Meadowbrook, PA 19046; telephone (215) 947-3000.

OB/GYN Board Certified or Board Eligible—Possibility of solo or group association. 243 bed Catholic Hospital located in the Laurel Highlands of South Central Pennsylvania. Progressive community, located in area which provides year round recreational facilities, excellent schools with university campus at your door step. Send C.V. to T.R. Baranik, Administrator, The Mercy Hospital of Johnstown, 1020 Franklin St., Johnstown, PA 15905; or call collect (814) 536-4461-ext. 251-351-352.

Orthopedic Surgeon Wanted—Associate for well established Orthopedic Clinic in Eastern Pennsylvania. First year, salary plus percentage. Partnership after one year. Board eligibility required. No investment needed. Write Department 709, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

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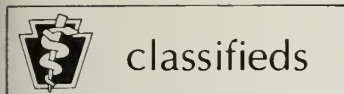
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classifieds

tions, third party requirements. Write Department 718, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

Physician's Assistant Student seeks an eight week preceptorship with a physician in the Valley Forge to west of Philadelphia area for June-July 1977. Please contact Renee Wilkins, Mallview Apts., 9E-2, Red Mill Rd., Rensselaer, NY 12144; (518) 449-7084.

Neurologist—Interested in private practice. Hospital based academy setting, in group or solo. Has comprehensive experience in clinical neurology, EEG, and neuroradiology. Interested in Philadelphia and surrounding; other locations will be considered. Write Department 717, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

POEMS WANTED

The Pennsylvania Society of Poets is compiling a book of poems. If you have written a poem and would like our selection committee to consider it for publication, send your poem and a self-addressed stamped envelope to: Pennsylvania Society of Poets, 1 W. Baltimore Ave., Lansdown, PA 19050.

FOR SALE

Spacious physician's offices and large house for sale. Ebensburg, a beautiful residential town, located high in the Alleghenies (2200 ft.—western Pennsylvania near Johnstown). Separate, multiple entrances to offices and to residence and well isolated from each other, as house was built for this purpose. J. O. Bennett, 121 Julian St., Ebensburg, PA 15931; (814) 472-7081.

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Modern Physician Offices and/or Equipment available as physician disabled. Well equipped. Lab, x-ray, complete cardiopulmonary resuscitation equipment, etc. In community 30 miles west of Pittsburgh. Write Department 715, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

Large Ophthalmological Office and clinic buildings. Living space for two families. Four offices and operating area for walk in and walk out surgery. Complete contact lens department and complete optical department. Philadel-

phia. For information call Philip LiVolsi (609) 767-6622, 47 State Highway, Berlin, NJ 08009.

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MISCELLANEOUS

The New York Society of Acupuncture for Physicians and Dentists, Inc., will give its 4th Postgraduate Course in acupuncture for beginners and advanced students at the New York University Medical Center, Nov. 3-7, 1976. Please write for application to Dr. S. J. Yue, Secretary, 115 E. 61 St., New York, NY 10021; or phone mornings (212) 245-4737.

Biomedical Electronics Service—Repairs medical, laboratory, and other electronic equipment. Will install and remove x-ray equipment. Walker Electronics, 117 Sylvan Terrace, Harrisburg, PA 17104; telephone (717) 238-1369.

Individual Idea Box

Print one of your ideas on this coupon. There's a tendency for ideas to become too generalized as people try to reach consensus, so try to be as specific as possible. Also, print as legibly as you can so others can read your ideas.

Name

County

Send to:

Committee on Objectives
Pennsylvania Medical Society
Box 301, Lemoyne, PA 17043

• Indicates membership in the Pennsylvania Medical Society at time of death.

• **John M. Apple**, Bethlehem; Jefferson Medical College, 1949; age 53, died March 31, 1976. He was assistant chief of service and an associate in urology for St. Luke's Hospital. His wife, three sons, a daughter, two brothers, and two sisters survive him.

• **Philip S. Barba**, Philadelphia; University of Pennsylvania School of Medicine, 1923; age 80; died March 27, 1976. He became associate professor of pediatrics for the University of Pennsylvania Graduate School of Medicine in 1946, associate professor of pediatrics for Temple University School of Medicine in 1948, associate professor of preventive medicine and pediatrics for Penn in 1956, and associate dean of the Penn medical school in 1958, retiring in 1965. He was a past president of the American Academy of Pediatrics and the Philadelphia Pediatrics Society, served on President Eisenhower's Citizens' Committee on the Fitness of American Youth, and was a member of the National Advisory Committee that supervised the distribution of the Salk vaccine. A son, William P. Barba, II, M.D., survives him.

• **Harry J. Bennett**, Ebensburg; Baltimore Medical College, 1906; age 94; died April 8, 1976. Before his retirement he had practiced medicine for 70 years. In 1956 he was named General Practitioner of the Year in Cambria County. Information regarding survivors is unavailable at this writing.

• **Charles R. Bost**, Scranton; Ohio State University School of Medicine, 1967; age 34, died April 17, 1976. A diplomate of the American Board of Internal Medicine and the American Board of Cardiology, he was director of the echocardiology laboratory at Mercy Hospital, consultant cardiologist for Moses Taylor and Scranton State General Hospitals, and director of the postgraduate course in intensive and coronary care at Mercy Hospital's School of Nursing. He was president elect of the Keystone Chapter of the American Heart Association. His wife, parents, three sons, and a sister survive him.

• **John E. Bryson**, Pittsburgh; University of Pittsburgh School of Medicine, 1930; age 69, died April 18, 1976. He was an associate professor on the clinical faculty of the University of Pittsburgh School of Medicine. He was Medical audit review chairman and former chief of staff for St. John's Hospital, and a staff physician and administrator for Magee-Womens Hospital. He was a fellow of the American College of Surgeons, the International College of Surgeons, and the American College of Obstetrics and Gynecology. He is survived by four daughters.

• **Arthur B. Hamilton**, Winston-Salem, N.C.; University of Pennsylvania School of Medicine, 1915; age 86; died April 1, 1976. He had practiced in Bethlehem for 55 years until his retirement. A niece and nephew survive him.

• **John L. Hamilton**, Pittsburgh; University of Pennsylvania School of Medicine, 1951; age 69; died March 28, 1976. He was secretary of the Pittsburgh Urological Society 1950-55 and president 1955-56. He is survived by his

wife and four sons.

• **Peter A. Herbut**, Philadelphia; McGill University Faculty of Medicine, Montreal, Canada, 1937; age 63; died March 31, 1976. He became president of Jefferson Medical College in 1967, and was largely responsible for its rechartering as Thomas Jefferson University in 1969. He had joined the Jefferson faculty in 1939 as assistant professor of pathology. Later he served as professor and chairman of the department of pathology until his inauguration as president. He was awarded an honorary doctor of science degree by the Philadelphia College of Pharmacy and Science and by Washington and Jefferson College. Other honors received include the McCrae Award of the Jefferson Society for Clinical Investigation, the Burdick Award of the American Society of Clinical Pathologists, and the Schaffret Award of the medical alumni of St. Joseph's College. His wife and two daughters survive him.

• **Richard H. Jackson**, Erie; Case Western Reserve University School of Medicine, 1938; age 64; died March 31, 1976. His wife, a daughter, and a brother survive him.

• **William C. Kinsey**, Erie; University of Pittsburgh School of Medicine, 1943; age 57; died April 21, 1976. He was president of the Erie County Medical Society in 1963, secretary 1958-62, a member of the Board of Directors 1963-65, 1967, and 1972, and on the Board of Censors 1965-68. He was former chief of pediatrics for Saint Vincent Health Center, and a past president of the Erie County Pediatric Society and the Northwestern Pennsylvania Chapter of the American Heart Association. His wife, four sons, his mother, and a sister survive him.

• **George M. Laws**, Philadelphia; University of Pennsylvania School of Medicine, 1905; age 94; died April 22, 1976. He was chief surgeon of the department of gynecology for Presbyterian Hospital and was an associate in gynecology at the Hospital of the University of Pennsylvania. His wife, a daughter, and a son survive him.

• **George Leibold**, Pittsburgh; University of Pittsburgh School of Medicine, 1910; age 88; died March 30, 1976. His wife, two sons, one of whom is Robert W. Leibold, M.D., and one daughter survive him.

• **Arthur S. Ninomiya**, Wellsboro; Boston University School of Medicine, 1944; age 57; died April 8, 1976. He was on the staff of Blossburg State Hospital for 20 years until its closing in 1973. He was a fellow of the Royal Society of Medicine, the Royal Society of Health, and the American College of Surgeons. His wife, a son, and a daughter survive him.

• **Paul F. Rosenstein**, Lansdale; New York University School of Medicine, 1962; age 41; died April 23, 1976. His wife and five daughters survive him.

• **Robert H. Stroh**, Wyoming; Hahnemann Medical College and Hospital, 1926; age 78; died April 21, 1976. He had practiced medicine in Wyoming over 50 years and was a member of the Luzerne County Medical Society for as many years.

Pennsylvania Medicine

August 1976

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F S CHEEVER MD
30 POND RD
WELLESLEY MA



HIGHLIGHTS OF THE YEAR

Pennsylvania Medicine



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August 1976

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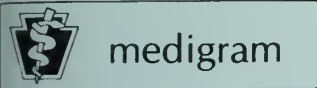
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COMMITTEE INVESTIGATES MEDICAID PROGRAM Henry H. Fetterman, M.D., of Allentown, chairman of the Council on Medical Service, called for the introduction of corrective legislation to assure medical assistance recipients of quality medical care in testimony before the House Subcommittee on Health July 22 in Harrisburg. At the first of three scheduled hearings on the medicaid program, Dr. Fetterman told the committee that crisis intervention--such as the emergency appropriation of \$32 million to prevent a deficit in fiscal year 1975-76--is an "inappropriate solution to an ever recurring problem." In calling for corrective legislation, he said, "...the current payment of \$6.00 per office visit is grossly inadequate...coupled with excessive paperwork and long delay in payment (it) will... discourage physicians from participating in the program." He called the posture of the Department of Public Welfare "counterproductive" because it forces medicaid patients into hospital emergency rooms and outpatient clinics, where "costs are staggering in comparison with costs in a physician's office." Dr. Fetterman reminded the committee that since 1967 the State Society has recommended that the Department of Health be designated the single state agency for Title XIX (medicaid) and be responsible for supervising the quality and availability of medical care, utilization and medical audit procedures, medical fees, and all matters that relate specifically to medical care.

CLINICAL LAB DECISION APPEALED The State Society July 26 appealed to the Supreme Court the dismissal by Commonwealth Court of the Society's suit to prevent Department of Health control of laboratories in private physicians' offices. As soon as the appeal was filed, Commonwealth Court again issued an injunction preventing the health department from inspecting laboratories in physicians' offices until the Supreme Court has rendered a decision. The decision to appeal was made by the Board of Trustees July 19.

PENNSYLVANIA DEPARTMENT OF HEALTH
INFLUENZA VACCINE ORDERS AND CERTIFICATION RECORD

SECTION I. (To be filled out by the physician requesting the vaccine)

NAME _____ COUNTY _____
OFFICE ADDRESS _____ OFFICE TELEPHONE _____

Number of Doses Ordered _____ Type Desired _____
Monovalent ☐ Check One Only
Bivalent ☐

Please Read and Sign Below:
I certify that I have received the above ordered number and type of Influenza vaccine doses. I understand I may not charge my patients for the cost of this vaccine, however, I may charge a fee to administer it. Further, I agree to return to the issuing office a *Consent Form/Data Sheet* for each dose of vaccine I administer with the knowledge that if I do not, I will not receive additional doses. Finally, I agree to return all the unused and partially used vials of Influenza vaccine when I have completed giving Influenza Immunizations for the current season.

Is This A Re-Order? Yes ☐
No ☐ _____
Physician's Signature

SECTION II. (To be filled out by the Issuing Office for all orders)

Number Doses Issued _____ Type Mono ☐ Manufacturer _____
BI ☐ Lot Number _____
Issued By _____ Health Center _____
Person's Name Indicate County

SECTION III. (To be filled out by Issuing Office for re-orders only)

Number of doses Issued from last order _____ *Note: These three numbers should agree
Number of Consent Form/Data Sheets returned _____ before a reorder is granted.
Number of doses still in physician's office _____

STATE GEARED FOR IMMUNIZATION

Secretary of Health Leonard Bachman, M.D., has announced that the Department of Health is prepared to immunize Pennsylvanians against A/New Jersey influenza as soon as the vaccine is released, which is expected to be the end of August. The lower half of this page contains the form to be used by physicians to obtain vaccine from county health offices for use in their private practices. No charge may be made for the vaccine, but a fee for its administration is permitted. The high risk category of the population is to be immunized first, with bivalent vaccine. This group includes persons of all ages who have such chronic health problems as: (1) heart disease of any etiology; (2) chronic bronchopulmonary disease; (3) chronic renal failure; and (4) diabetes mellitus. Details of the program appear on page 47.

ACT 111 AMENDED

Technical amendments to the state's new malpractice law, Act 111, were signed into law July 15 by Governor Milton J. Shapp. Major changes are:

- (1) A requirement that health care providers other than hospitals who conduct more than 50 percent of their practices within the Commonwealth insure or self-insure in the amount of \$100,000 per occurrence and \$300,000 per annual aggregate. They will be assessed 10 percent of their annual premium for and will be covered by the Catastrophe Loss Fund. Those with less than 50 percent of their practices in Pennsylvania must insure up to \$200,000/\$600,000, and will not be required to pay into, nor will they be covered by, the Fund;
- (2) The definitions section of the Act is expanded to include primary health care centers, including rural health centers but excluding Health Maintenance Organizations;
- (3) Allows health care providers to self-insure. The insurance commissioner is empowered to review, audit, and approve or disapprove self insurance programs.

ARGONAUT SUES STATE SOCIETY

The Pennsylvania Medical Society received notice July 29 that Argonaut Insurance Co. had filed suit in U.S. District Court for the Eastern District of Pennsylvania to break its agreement to provide malpractice insurance to member physicians. The suit is another in a long series of Argonaut attempts to scuttle its contractual obligation. The State Society has instructed legal counsel to take all necessary steps to deal with the latest harassment. Details will appear in a forthcoming all member letter.

INSTRUCTIONS FOR COMPLETING THE INFLUENZA VACCINE ORDER AND CERTIFICATION RECORD

SECTION I.

This section is to be filled out by the physician and signed prior to picking up vaccine at the issuing office. The physician's name and address are to be entered in the top left three lines. The county and telephone number should be entered directly to the right of the address. Enter in the space indicated the number of doses desired. Only under unusual circumstances and with proper justification will more than 100 doses be issued at one pick up. Regardless of the amount desired, it should be in multiples of 10. Check the type of vaccine desired, either bivalent for high risk individuals or monovalent for the non high risk. Order only one type of vaccine per order record. Check whether or not this order is a re-order. If it is a re-order you must supply the issuing office a *consent form/data sheet* for each dose administered equaling the amount of your last order. *Sign the form.*

SECTION II.

This section is to be filled out by the issuing office for all orders. Indicate the number of doses issued and the type vaccine issued. Copy from the vaccine vial the manufacturer's name and the lot number and write this on the form. The person who issues the vaccine should write his/her name on the form. The county of the issuing office should be indicated also. **Note: Read the instructions in Section I for restrictions on vaccine issuance. Also, review Section I for completeness.**

For each dose of vaccine given, *one consent form* and *one consent form/data sheet* should also be given. The physician should be informed that *one consent form/data sheet* should be returned for each dose given when he reorders.

SECTION III.

This section is to be filled out on *re-orders only*. Check the physician's last order and indicate the number of doses issued. Count the number of *consent form/data sheets* returned with this *re-order*. The three numbers should agree. If they do not, the physician cannot be granted the re-order.



HIGHLIGHTS

As the Pennsylvania Medical Society approaches the 1976 Annual Session of the House of Delegates, official reports are prepared for consideration of the House. In this section of **Pennsylvania Medicine**, highlights of the reports are presented. All component county medical societies and all delegates receive copies of the *Official Reports Book*, which are available to any member on request. This is a brief summary of what the Society has done since the 1975 Annual Session.



The Board of Trustees and Councilors



William C. Ryan, M.D., vice chairman of the Board



The 1975 Annual Session of the House of Delegates



David S. Masland, M.D.,
delivering his 1975 Annual Session address



Those who write Pennsylvania Medical Society history may someday view this as M.C. II or the second year of the malpractice insurance crisis. A key event in the crisis occurred in Lancaster on October 7, 1975, when the Society's House of Delegates "reluctantly" told the State House of Representatives to concur in Senate amendments to H.B. 1367 and send it to the governor. A few days later the House of Representatives did concur and on October 15 Governor Milton J. Shapp signed Act 111, the Health Care Services Malpractice Act of 1975. Although the Administration and the Legislature had failed to reform the tort system as originally recommended by the State Society in House Bill 805 they had taken a timid "first step."

A number of leadership posts changed hands at the Lancaster meeting. David S. Masland, M.D., of Carlisle, became the 126th president of the Society. William J. Kelly, M.D., of Pittsburgh, became president elect and John V. Blady, M.D., of Philadelphia, was elected vice president. George A. Rowland, M.D., of Millville, was elected chairman of the Board of Trustees and William C. Ryan, M.D., of Somerset, was elected vice chairman. Two new trustees were elected—Richard L. Huber, M.D., of Scranton, representing the Third District, and Carol N. Maurer, M.D., of Oil City, representing the Ninth District. Dr. Maurer is the first woman to serve on the Board of Trustees.



George A. Rowland, M.D., Chairman of the Board



The chain of command—Dr. Masland; President Elect William J. Kelly, M.D.; and Vice President John V. Blady, M.D.



New Board members, Carol N. Maurer, M.D., and Richard L. Huber, M.D., seated on either side of Raymond C. Grandon, M.D.



John B. Lovette, M.D., speaker of the House



D. Ernest Witt, M.D., vice speaker

Soon after the Lancaster meeting it became apparent that malpractice insurance would remain the Society's first priority. The Ad Hoc Committee on Malpractice Insurance, chaired by Dr. Masland, plunged into still another round of meetings. Besides Donald E. Harrop, M.D., of Phoenixville, chairman of the Council on Governmental Relations, and J. Joseph Danyo, M.D., of York, chairman of the Commission on Professional Liability Insurance, the committee included William J. Kelly, M.D., of Pittsburgh, president elect; and Clive R. Waxman, Williamsport, representing The Hospital Association of Pennsylvania.

The ad hoc committee's first priority became Act 111, and its technical flaws, such as the plight of the physician practicing on the state's border. Addressing these problems was a joint committee of the House and Senate as mandated by Act 111. Known as the 1006 Committee, and chaired by Insurance Commissioner William J. Sheppard, it began drafting corrective amendments. Representatives of the Society's ad hoc committee attended its meetings and provided assistance. At the same time, the ad hoc committee began drafting its own amendments to reform the tort law as directed by the Society's House of Delegates.



The Ad Hoc Committee on Malpractice Insurance

Suddenly new problems with Argonaut surfaced. The company announced plans to cancel 59 policies. PMS countered, invoking its contractual right to review all proposed cancellations through the Commission on Professional Liability Insurance. Following due process, only four policies were cancelled with seven more scheduled for experience rating.

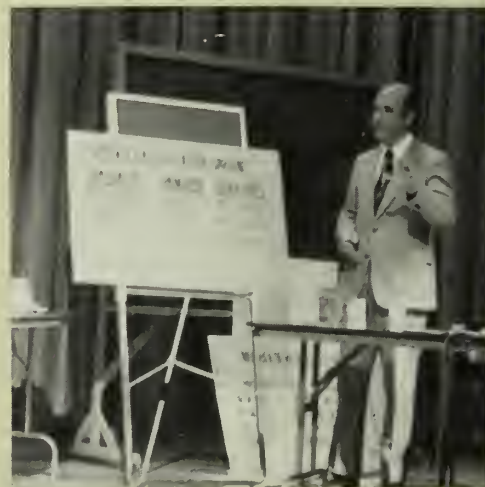
In March Argonaut filed for another rate increase. This time 42 percent overall, with physicians in Classes I and II in Territory I taking the brunt at over 203 percent. One reaction of the ad hoc committee was to accelerate its development of a Society-owned insurance company. In preparation for testimony before the insurance commissioner, the Society hired an independent actuary from Woodward and Fondiller, Division of Martin E. Segal Co., Inc., New York City. The ad hoc committee also authorized a professional marketing survey of PMS members' receptiveness to a Society-owned insurance company.

On March 30, in Harrisburg, testifying before the insurance commissioner, Dr. Masland charged the

insurance industry with "bad faith." He said significant concessions had been made to the insurance industry to get Act 111 through the Legislature, concessions such as the four-year statute of limitations for insurance companies, and the subsidization of the Joint Underwriting Association (JUA) by providers—concessions which were supposed to enable private companies to continue to write malpractice insurance in Pennsylvania.

Instead, carriers such as Wausau, Aetna and Hartford abandoned the state. Dr. Masland also criticized the Medical Protective Company for its restrictive marketing policies, which have impaired insurance competition in Pennsylvania. Later in those hearings, PMS refused to support the Argonaut rate increase. Under certain conditions the Argonaut data could be interpreted to permit a decrease.

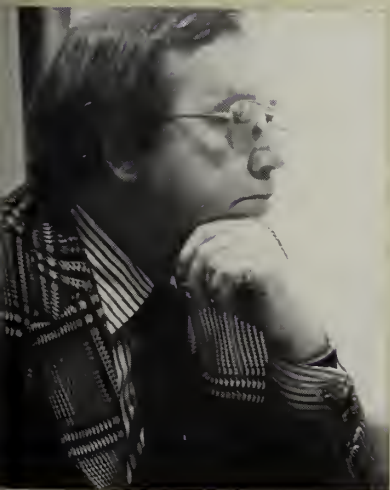
The next malpractice chapter was written July 11, 1976 at the Penn Harris Motor Inn, Camp Hill, when a Special Session of the House of Delegates approved the launching of a captive insurance company approved by the Board of Trustees May 19.



Dr. Masland testifying at Insurance Department hearings



The Commission on Accreditation



James A. Raub, M.D., chairman of the Council on Education and Science

In the midst of this crisis the deadline for the Society's six year old continuing education requirement arrived. As June 30 approached, questions poured in. The program, though simplified through the years, remained a source of confusion for members. A final count awaited processing by the AMA. Meanwhile the Commission on Accreditation met on a monthly basis to handle waivers and two new employees were added to handle the processing and computer updating. Thus, with no little wheezing, clanking, and rattling, the Society finally embarked down the required continuing education road.

The Council on Governmental Relations, after a year of high visibility on malpractice, lowered its profile in pursuit of the Society's regular agenda. Although the legislature passed a child abuse law and a TV tube safe disposal bill, it spent as little time in Harrisburg as possible, being much concerned with the 1976 General Election.



Donald E. Harrop, M.D., chairman of the Council on Governmental Relations



The Council on Governmental Relations



The Council on Medical Service



The Council on Medical Service



The Commission on Professional Liability Insurance



*Henry H. Fetterman, M.D., chairman of
the Council on Medical Service*



The Commission on Professional Liability Insurance

Angered by confiscatory malpractice premiums, last year's House of Delegates concluded its meeting with a resolution aimed at prevailing fee programs. Despite an appeal by the reference committee for rejection of Resolution 75-19, delegates recommended "the adoption of a uniform charge class for all prevailing fee plans throughout the state." Amended Resolution 75-19 was approved amid cries of "Equal pay for equal work." Subsequent research by Blue Shield and review by the Council on Medical Service has resulted in the question being returned to the House of Delegates this year for further debate. The Council on Medical Service also represented the Society in a study of surgery mandated by the Pennsylvania Insurance Department. At the request of Insurance Commissioner Sheppard, the Society specialty advisory committees will review data supplied by Blue Shield and hospitals.



Cooperative warehouse

If not for the malpractice crisis, the birth of the Pennsylvania Medical Cooperative would have received the attention it deserved. This remarkable physician-owned and operated business opened its doors in October 1975 with a catalogue of 250 medical supplies. A few months later its expanded catalogue offered more than 1,300 items, making it competitive with the major medical supply houses

in the state. For the first time, the Society learned the true meaning of the word "competition." After some very shaky months, the co-op began to fight back with specials of the month, bonuses, and other promotions. Sales picked up and by June the co-op was selling 18 tons of medical supplies a month. Even so, its future remained in the balance. On May 19, the Board of Trustees

voted to seek financial support for the co-op from the House of Delegates. No doubt the final chapter on the cooperative will be written by members themselves week by week as they shop for their office supplies. Pointing to a reorder rate of 90 percent, H. Robert Davis, M.D., of Boiling Springs, Cooperative president, has said, "Try it, you'll like it."



The Interspecialty Committee



Long Term Care Seminars

The Society conglomerate, the Council on Education and Science, continued its many activities. The Council offered more practice management training seminars for both senior residents and practicing physicians. Taught by consultants of national reputation, the courses attracted a growing number of physicians. In 1975-76, 335 physicians attended nine seminars offered in Pittsburgh, Harrisburg, and Philadelphia. With the government requirement that nursing homes have a medical director, a whole new training need arose. The council stepped into this vacuum and offered a symposium, "The Role of the Medical Director in the Skilled Nursing Facility." More than 300 physicians, nurses, and administrators attended the two sessions. At its March meeting, the Board of Trustees, noting the growing problems in the care of the aged, created a Commission on Long Term Care under the Council on Medical Service.



Long Term Care Seminars

What began as a desk-drawer operation five years ago matured into a full fledged department in March when the Board created the Department of Specialty Society Services. The department provides staff services to the Interspecialty Committee, and by arrangement, to the Pennsylvania Psychiatric Society, the Pennsylvania Society of Anesthesiologists, the Southeastern Chapter of the American College of Surgeons, the Urological Association of Pennsylvania, and the College of Nuclear Medicine.



Focusing on the 1976 elections, the Pennsylvania Medical Political Action Committee (PaMPAC) produced a twelve minute multi-media recruiting show. Premiered at Officers' Conference, the show launched a successful statewide drive to enroll PaMPAC members. It was booked into county medical society and hospital medical staff meetings weekly through the spring and fall. Many doctors became aware of PaMPAC for the first time through the show.

At the direction of the federal government, the Society once again prepared to dismantle the Susquehanna Valley Regional Medical Program. This time, prospects for phase out looked firmer than at any time in the past because of the swift ascendancy of the HSAs, the new Health Systems Agencies created by the National Health Planning and Resources Development Act of 1974. The HSAs will replace comprehensive health planning, Hill-Burton funding, and regional medical programs.

Because of a series of implementing dates in the new law, PMS moved swiftly to inform county medical societies about the awesome implications of Public Law 93-641. The communications division produced a slide show which was used extensively by the Commission on Health Planning in regional meetings across the state. The Society assisted areas dissatisfied with their HSA boundaries in appealing and in the five-county Philadelphia area, for example, revisions were secured. The need for strong physician involvement in HSAs continues, heightened by their consumer majority orientation. Only an informed and aroused PMS membership can exert the necessary counterbalancing leadership.





Robert Poole, M.D., chairman of the Council on Professional Relations and Services



Thaddeus Lekawa, M.D., chairman of the Advisory Committee on Membership Recruitment

The membership recruitment work of the Council on Professional Relations and Services began to show results with Society membership headed for new records. Called the Ambassador Program, the recruitment drive is spearheaded by a group of doctors willing to personally solicit new members. After its successful pilot run in a combined Dauphin-York County run, the program moved to Chester and later Montgomery County. Meanwhile the council continued to develop new membership benefits.



Chester County Ambassadors



Matthew Marshall, Jr., M.D., founding president of the Foundation

Recipient of national recognition for operating the country's first PSRO Support Center, the Pennsylvania Medical Care Foundation has been requested by HEW to continue as a PSRO Support Center through September 1977. The Foundation moved on to new areas, launching a series of highly successful training programs which were quickly oversubscribed by other states. It also successfully negotiated with PAID Prescriptions to administer the peer review portion of PAID's contract with the Department of Welfare. 1976 marked another milestone for the Foundation as the reins of leadership passed from Matthew Marshall, Jr., M.D., of Pittsburgh, the Foundation's first president, to Sidney O. Krasnoff, M.D., of Philadelphia.



*Sidney O. Krasnoff, M.D.,
new president of the Foundation*

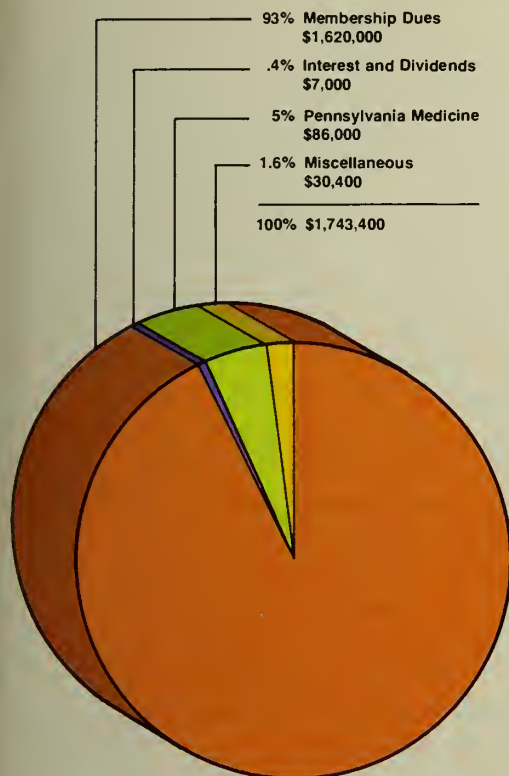


Orlo G. McCoy, M.D., chairman of the Committee on Quackery

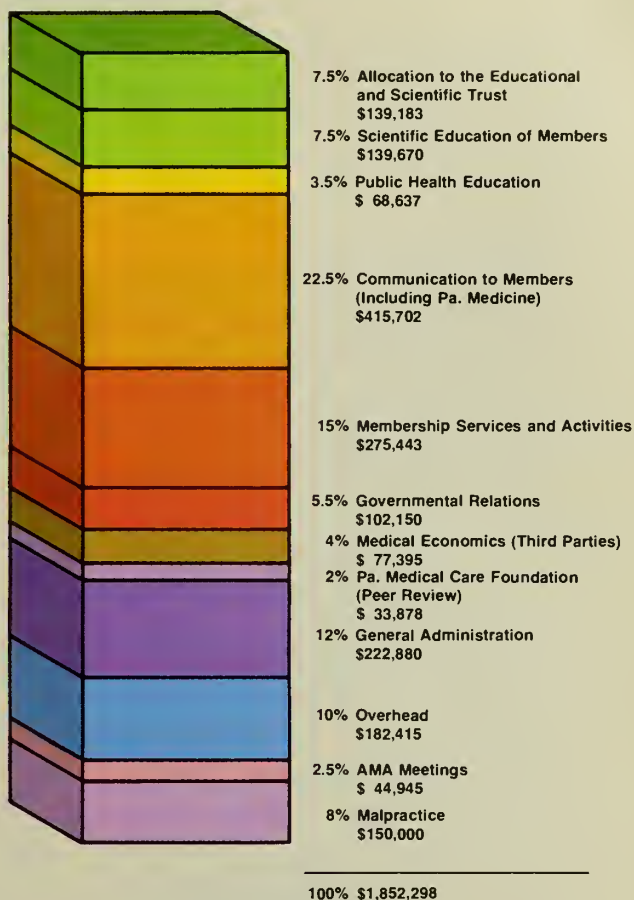
The Committee on Quackery, launched four years ago, and toting a war chest of some \$45,000 in the Quackery Defense Fund, came into prominence for the first time. It distributed antichiropractic literature to the state's public school guidance counselors, thereby engendering the ire of chiropractors across the country. The committee also launched a series of highly successful radio spots on nutrition. Later it coordinated the fight to block chiropractors from the state's black lung program.

Thus PMS, in the midst of the malpractice insurance crisis, paused once again to battle charlatans and cultists, a war which began 128 years ago on that April day in Lancaster when the Pennsylvania Medical Society was born.

SOURCES OF PMS INCOME



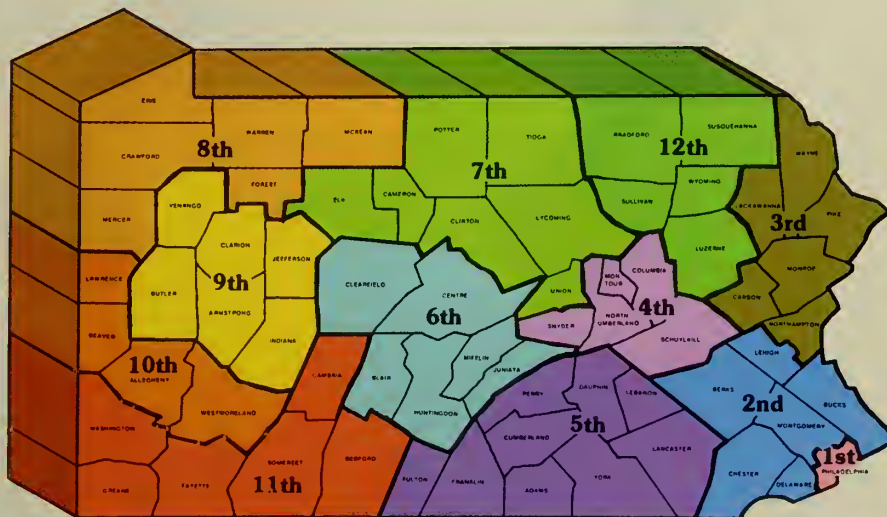
OVERALL BUDGET



BOARD OF TRUSTEES AND COUNCILORS

1. Donald R. Cooper, M.D.
2. Leroy A. Gehris, M.D.
3. Richard L. Huber, M.D.
4. George A. Rowland, M.D.
5. Raymond C. Grandon, M.D.
6. Joseph M. Stowell, M.D.
7. Kenneth L. Cooper, M.D.
8. David J. Keck, M.D.
9. Carol N. Maurer, M.D.
10. David W. Clare, M.D.
11. William C. Ryan, M.D.
12. Orlo G. McCoy, M.D.

Above are the Society's building blocks reflecting the Society's 1976 budget as it stood July 1. When the Board of Trustees learned that the malpractice crisis would continue, it reopened an account to support what now has become a crusade for malpractice insurance reform. So far in 1976, \$150,000 has been budgeted for this purpose. In 1975 the Society spent \$253,000 on malpractice activities.



The current Board also includes as voting members this year President David S. Masland, M.D., President Elect William J. Kelly, M.D., and Immediate Past President A. Reynolds Crane, M.D. Sitting with the Board as nonvoting members are John B. Lovette, M.D., speaker of the House of Delegates, D. Ernest Witt, M.D., vice speaker, and G. Winfield Yarnall, M.D., secretary.



John P. Hubbard, M.D.

In this Bicentennial year, The Board of Trustees determined to add to the list of the many honors and awards of John Perry Hubbard, M.D., the Pennsylvania Medical Society's Distinguished Service Award. The Board chose Dr. Hubbard for "his service to the science and art of medicine and for his life of activity which reflect great credit on his profession." The medal will be presented at the state dinner during the 1976 Annual Session of the House of Delegates.



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0.5 Gm tablets



This new design will help pharmacists, physicians, nurses, and patients identify Orinase by name and manufacturer. The number on the tablet is for identification and is not related to tablet strength.

You may wish to advise your patients that this change is taking place.

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RECENT CHANGES

federal register

Providing Drug Information to Physicians

Informational Bulletin #433-76

National Health Insurance

special report
Malpractice insurance:

drug bulletin

Health care doesn't need more red tape

Drug firms challenge MAC rules

Drug Substitution

The Economic Dimension of Health Progress
RESEARCH

Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

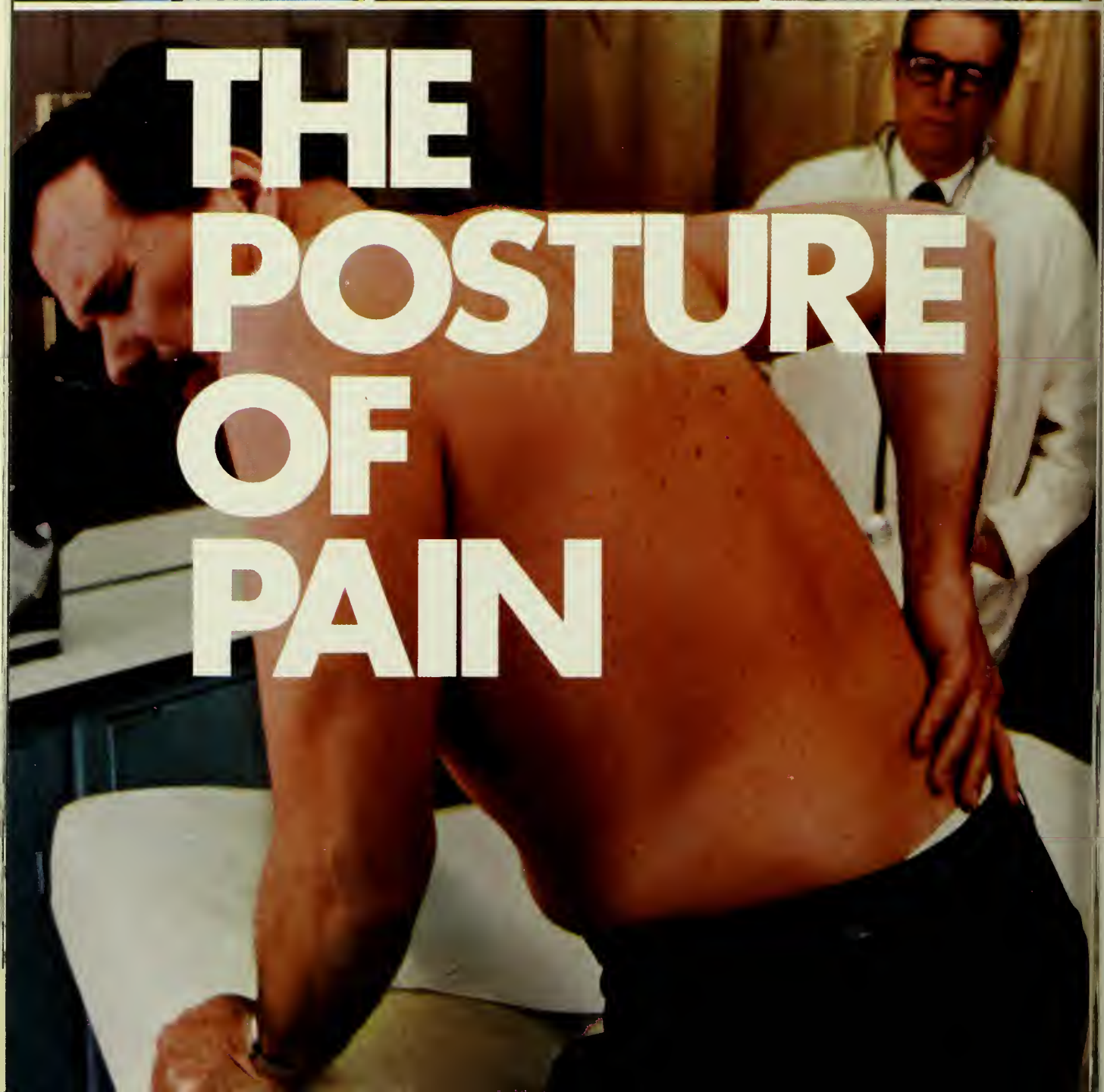
It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
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THE POSTURE OF PAIN



The promise of Soma in the "low-back" patient: relief of discomfort... improved function

In 3 double-blind, randomized, placebo-controlled studies¹⁻³ of patients with acute, painful musculoskeletal disorders affecting the back, Soma helped effect...

- significant relief of discomfort, stiffness and other symptoms
- significant improvement in range of motion as measured by objective tests of function.

Add Soma to your standard regimen for low-back disorders...and, if necessary, add your choice of analgesic. Then let your patient report the results.

In acute, painful low-back disorders

Soma[®] 350 (carisoprodol) 350 mg tablets for measurable relief

Indications: Carisopradol is indicated as an adjunct to rest, physical therapy, and other measures for the relief of discomfort associated with acute, painful musculoskeletal conditions.

Contraindications: Acute intermittent porphyria and allergic or idiosyncratic reactions to carisopradol or related compounds such as meprobamate, mebutamate, tybamate.

Warnings: *Idiosyncratic Reactions:* Rarely, extreme weakness, transient quadriplegia, dizziness, ataxia, temporary vision loss, diplopia, mydriasis, dysarthria, agitation, euphoria, confusion and disorientation have appeared within minutes or hours of the first dose. These usually subside in several hours but supportive and symptomatic therapy, including hospitalization, may be necessary.

Pregnancy and Lactation: Safe use not established; weigh potential benefits against potential hazards in pregnancy, nursing mothers (concentrations in breast milk are two to four times that in plasma), or women of childbearing potential.

Children Under Twelve: Not recommended.

Potentially Hazardous Tasks: Driving a motor vehicle or operating machinery.

Additive Effects: Effects of carisopradol and alcohol, other CNS depressants or psychotropic drugs may be additive.

Drug Dependence: Use cautiously in addiction-prone patients.

Precautions: To avoid excess accumulation, use caution in patients with compromised liver or kidney function.

Adverse Reactions: *Central Nervous System:* Drowsiness, dizziness, vertigo, ataxia, tremor, agitation, irritability, headache, depressive reactions, syncope, insomnia, idiosyncratic reaction (see "Warnings").

Allergic or Idiosyncratic: In previously unexposed patients, these are usually seen after 1-4 doses and include rash, erythema multiforme, pruritus, eosinophilia, fixed drug eruption with cross reaction to meprobamate. Asthmatic episodes, fever, weakness, dizziness, angioneurotic edema, smarting eyes, hypotension and anaphylactoid shock may be manifestations of severe reactions. In such cases, stop carisopradol and initiate appropriate treatment (e.g., epinephrine, antihistamines, corticosteroids).

Cardiovascular: Tachycardia, postural hypotension, facial flushing.

Gastrointestinal: Nausea, vomiting, hiccup, epigastric distress.

Hematologic: Leukopenia and pancytopenia (an carisopradol plus other drugs).

Usual Adult Dosage: One 350 mg tablet three times daily and at bedtime.

Overdosage: Has produced stupor, coma, shock, respiratory depression, and, very rarely, death. The effects of an overdosage of carisopradol and alcohol or other CNS depressants or psychotropic agents can be additive even when one of the drugs has been taken in the usual recommended dosage. Empty stomach, treat symptomatically; cautiously give respiratory assistance, CNS stimulants, pressor agents as needed. Carisopradol is metabolized in the liver and excreted by the kidney. Diuresis and dialysis have been used successfully with related drug meprobamate. Carefully monitor urinary output; avoid overhydration; observe for possible relapse due to incomplete gastric emptying and delayed absorption.

Before prescribing, consult package circular or latest PDR information.

1. Hindle, T.H. III. Calif. Med. 117:7 (Aug.) 1972, 2,3. Unpublished Data on file, Medical Department, Wallace Laboratories, Cranbury, N.J.



MDs in the news

Robert C. Eyerly, M.D., Danville, was recently named chairman of the Governor's Task Force in Cancer Control, which is concerned with studying the role of government in cancer programs. Dr. Eyerly as chairman is responsible for overseeing the work of the various subcommittees of the task force. **Alton I. Sutnick, M.D.**, Philadelphia, is chairman of the subcommittee on cancer detection; **Roland A. Loeb, M.D.**, Lancaster, is chairman of the subcommittee on data base; and **Dan Elliott, M.D.**, Pittsburgh, is chairman of the subcommittee on treatment and rehabilitation. The Task Force recently held public hearings in Philadelphia and Hershey in order to obtain recommendations for a cancer control program in Pennsylvania.

The Medical College of Ohio recently awarded an honorary doctor of science degree to **William A. Sode-man, Jr., M.D.**, Toledo. Dr. Sodeman, dean emeritus and emeritus professor of medicine of Jefferson Medical College, Philadelphia, is currently a part time clinical professor of medicine for the Medical College of Ohio.

He is a past president of the American College of Physicians and the American College of Cardiology.

A new medical clinic, the G. W. Kahle Medical Center, Inc., was recently dedicated and named in honor of **G. W. Kahle, M.D.**, who has practiced in the Greenville, Hadley, Sandy Lake, and Marienville areas for a total of 66 years. The clinic is a double-wide modular home with waiting rooms, reception area, and three examining rooms.

David Rosenthal, M.D., assistant medical director of Moss Rehabilitation Hospital was installed as president of the Philadelphia Society of Physical Medicine and Rehabilitation at the annual dinner of the group held recently in Philadelphia. Dr. Rosenthal is assistant professor of Rehabilitation Medicine at Temple University Health Sciences Center, and affiliated with Albert Einstein Medical Center, Northern Division, Frankford Hospital, and Temple University Hospital.

Frank J. Menolascino, M.D., was chosen recently to receive the Ed-

ward A. Strecker Award of the Institute of Pennsylvania Hospital. Psychiatrist in chief of the Institute, he was chosen for his "skillful, pioneering leadership in the care of the mentally retarded," in which he has been actively involved for 15 years.

Mark M. Mishkin, M.D., Swarthmore, was elected president of the Association of University Radiologists during the organization's recent annual meeting in Boston. Dr. Mishkin is professor of radiology at the University of Pennsylvania School of Medicine and chief of the division of neuroradiology at the Hospital of the University of Pennsylvania.

William G. Jackson, M.D., was recently appointed program director for the family practice residency program at St. Vincent Health Center, Erie. He is responsible for developing and instituting a training program for young physicians in all phases of medicine.

The Lancaster City and County Medical Society recently cited **Irene B. Davis, M.D.**, for 50 years of medical service, 43 of which were spent in Lancaster. Dr. Davis is on the staff of Lancaster General Hospital and the courtesy staff of St. Joseph Hospital.

Charles L. Swisher, M.D., was recently elected to the board of directors of the Pennsylvania Chapter, American College of Emergency Physicians. He is director of the emergency department at Moses Taylor Hospital, Scranton.

Mayer A. Green, M.D., Pittsburgh, was awarded a certificate of appreciation for service as president for 1975-76 of the Association of Convalescent Homes and Hospitals for Asthmatic Children. The award was presented during the organization's annual post-congress meeting held recently in San Francisco.

Joe Mendels, M.D., professor of psychiatry at the University of Pennsylvania School of Medicine, was



R. PHILIP CUSTER, M.D., right, professor emeritus of the University of Pennsylvania School of Medicine, receives the Damon Award for Achievement in Pathology from Domenic F. Coletta, M.D., executive medical director of the Damon Corporation, during the Damon Clinical Colloquium, held recently in Philadelphia.

awarded the prestigious Hofheimer Prize for research during the American Psychiatric Association's recent convocation of fellows in Miami. He received the prize for his research on affective disorders.

The Dauphin County Medical Society presented a State Society 50 year award to **Hamblen C. Eaton, M.D.**, during a recent county society dinner meeting. Dr. Eaton is a former superintendent of Harrisburg State Hospital.

Ulysses E. Watson, M.D., was recently elected to the board of advisors of the Medical College of Pennsylvania. Currently director of the Eastern Pennsylvania Psychiatric Institute, he was recently appointed to head Saint Elizabeths Hospital in Washington, D.C.

During a luncheon of the Alumnae Association of the Medical College of Pennsylvania, **Eva F. Fox, M.D.**, and **Minerva S. Buerk, M.D.**, received Alumnae Achievement Awards. Dr. Buerk, a former president of the medical college's association, is president of the Philadelphia branch of the American Medical Women's Association. She is former chief of dermatology at Bryn Mawr Hospital and former visiting professor in dermatology at the college. Dr. Fox is a past recipient of the Mary F. and Christian R. Lindback Award for Excellence in Teaching and has been named an Outstanding Educator of America.

H. Arnold Muller, M.D., director of Emergency Health Services for the State, discussed statewide organization of emergency medical services at the 1976 International Congress on Emergency and Critical Care Medicine, held recently in Pittsburgh. Dr. Muller said that statewide efforts have been made to identify and correct emergency health service deficiencies; however, no sizable geopolitical regions have succeeded in developing a complete system of emergency health services. Dr. Muller is chief of the division of emergency medicine and associate professor of medicine for The Pennsylvania State College of Medicine at The Milton S. Hershey Medical Center, Hershey.

The American College of Obstetricians and Gynecologists recently recognized **Joseph Fescina, M.D.**, Hazleton, for 25 years of service as a founding fellow of the college. Dr. Fescina is associated with St. Joseph and Hazleton State General Hospitals.

Frank J. Theuerkauf, Jr., M.D., was elected recently as president of the Northwestern Pennsylvania Chapter of the American College of Surgeons. He is director of the residency program in colon and rectal surgery at Saint Vincent Health Center and on the medical staff of Hamot Medical Center.

The American College of Physicians recently named **Gershon W. Hepner, M.D.**, Hershey, and **William E. Schaeffer, Jr., M.D.**, Lebanon, as fellows.

Milton J. Freiwald, M.D., Philadelphia, recently spoke on statutory blindness to the New York second regional office of the Social Security Administration, Bureau of Disability Insurance, U.S. Department of Health, Education, and Welfare. Dr. Freiwald is medical advisor to the third regional office of the Social Security Administration Bureau of Disability Insurance in Philadelphia, and medical director and chief ophthalmologist to the Mac Sanders Memorial Eye Institute of Philadelphia.

Robert K. Nielsen, M.D., was recently chosen to receive a 1976 Mead Johnson Award for Graduate Training in Family Practice. He is a resident in family and community medicine at The Milton S. Hershey Medical Center, Hershey.

John G. Shutack, M.D., Lehigh, was recently named a fellow in the American Academy of Pediatrics.

The Crawford County Medical Society recently honored **Richard Jessup, M.D.**, who has retired after 28 years of practice in Meadville. **John Stolar, M.D.**, society president, and **Robert Moyers, M.D.**, secretary, presented an engraved silver bowl to Dr. Jessup during a regular meeting of the organization.

William B. Landis, M.D., Columbia, was recently elected a trustee of the Hahnemann Medical College Alumni Association. Dr. Landis has practiced in Columbia since 1958, is president of the Donegal School Board, vice president of the Columbia Hospital medical staff, and is a member of the governing board of St. Anne's Home.

Creighton McClintock, M.D., Ben Avon, was recently named president of the Western Pennsylvania Heart Fund. He is on the medical staff of Suburban General and St. John's Hospitals.



WILLIAM LIKOFF, M.D., left, professor of medicine and director of the William Likoff Cardiovascular Institute, Hahnemann Medical College and Hospital, salutes the late **Samuel Bellet, M.D.**, prominent Philadelphia cardiologist, during the recent dedication ceremony of Hahnemann's Samuel Bellet Building. Looking on are, left to right, **Mrs. Samuel Bellet**; **Wharton Shober**, president and chief executive of Hahnemann; **Mrs. William H. Roache**; **Rabbi Richard Steinbrink**; and **I. H. Krekstein**, chairman of Hahnemann's board of trustees.

A man with a mustache, wearing a white hard hat and a dark blue work shirt, is shown from the chest up. He has a white sling supporting his right arm, which is wrapped in white bandages. He is holding a black tool bag in his left hand. The background is dark, and a sign with the word "STRESS" is partially visible on the left. The lighting is dramatic, highlighting his face and the textures of his clothing and the sling.

Tough...

(even when
pain calls
for codeine)

but he may not have the stomach for APC.

Or the kidneys, for that matter.

Even bleeding time and platelet aggregation can be maximally prolonged by a single aspirin tablet.*

We took that into account in revising the formula of Phenaphen® with Codeine, and combined codeine (in any of three different strengths) with acetaminophen to complement the codeine with little risk of APC complications. While there's no anti-inflammatory activity, there's no aspirin to aggravate G.I. problems or adversely affect bleeding time. Similarly, there's no potential renal risk from phenacetin, and no caffeine to stimulate patients unnecessarily.

There is the convenience of telephone Rx under Federal law...and the complementary analgesic efficacy of acetaminophen.

Phenaphen® with Codeine. Not just for patients who might have a "compound" problem, but for almost every patient who needs codeine. It's a lot simpler than APC.

BRIEF SUMMARY

Contraindications: Hypersensitivity to acetaminophen or codeine

Warnings: *Drug dependence.* Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with same caution appropriate to oral narcotics. Subject to the Federal Controlled Substances Act.

Usage in ambulatory patients. Caution patients that acetaminophen and codeine may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery.

Interaction with other CNS depressants. Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) may exhibit additive CNS depression; when used together reduce dose of one or both.

Usage in Pregnancy. Safe use is not established. Should not be used in pregnant patients unless potential benefits outweigh possible hazards.

Precautions: *Head injury and increased intracranial pressure.* Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal condition. Acetaminophen and codeine or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

Special risk patients. Administer with caution to elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, or prostatic hypertrophy or urethral stricture.

Adverse Reactions: Most frequent are lightheadedness, dizziness, nausea, and vomiting; more prominent in ambulatory than in nonambulatory patients; some may be alleviated if patient lies down; other: euphoria, dysphoria, constipation and pruritus.

Drug Interactions: CNS depressant effect may be additive with that of other CNS depressants. See Warnings.

For symptoms and treatment of overdosage and full prescribing information, see package insert.



REVISED FORMULA

Phenaphen®
with **Codeine**
No.3 

Codeine Phosphate, USP-30 mg
(Warning: May be habit forming)
Acetaminophen, USP - 325 mg

to complement
codeine with
little risk of APC
complications

*Mielke, C.H., et al.: JAMA
235:613 (Feb. 9) 1976.

A-H-ROBINS

A. H. Robins Company
Richmond, Va. 23220



On going into the insurance business

With continued carrier withdrawal and skyrocketing premiums coupled with reductions in coverage, the malpractice crisis in Pennsylvania is far from solved. The Pennsylvania Medical Society's suit to force Argonaut to remain in the state until the termination of their present contract, June 1, 1979, was a bittersweet victory. Other states were not as successful in their quest. Although rates are ever-increasing, we have the advantage of having gained time in which to attempt legislative change.

To date, all of the measures undertaken have been short-term. The Pennsylvania Medical Society has been working on two long-term solutions which merit attention. First, the formation of a captive insurance company was approved in a special session of the House of Delegates on July 11, 1976. There will be decided advantages. Significant operational savings will be apparent because of low administrative costs and fewer high salaries. The peer review mechanism can be instituted to evaluate all claims and those nuisance suits that have no validity need not be settled out of court, at least, not without written consent of the physician involved. Finally, and most important, all classes of physicians will be able to obtain professional liability insurance.

The Society is striving for much needed litigation reform. Since the present court system of adjudicating malpractice claims has contributed heavily to the crisis, it is essential that reform in this

area be achieved if we hope to successfully initiate and sustain a captive insurance company. Of primary concern to physicians are substantial reduction or elimination of the contingency fee and prevention of discovery of amount of insurance coverage. Needless to say, these two will encounter stiff legal opposition. At the Pennsylvania Insurance Department hearings on rates for professional liability insurance held March 30-April 2, 1976, Dr. Masland stated, "At the time of the passage of Act 111 . . . , the Pennsylvania Medical Society said that the new law offered no real long term answers to the crisis in health care . . . we also pointed out that no legislative proposal would work that doesn't provide for: 1. Final binding arbitration; 2. A realistic two year statute of limitations; 3. Periodic rather than lump sum payments; 4. The direction of punitive damages to the State Board of Medical Education and Licensure rather than to the plaintiff; 5. A definition of informed consent which serves patients rather than the legal profession; 6. The limitation of awards to actual economic loss."

The problem is extremely complex and solutions, difficult to achieve. The State Society needs your advice and support to attain these long term goals in the interest of health care in Pennsylvania.

David A. Smith, M.D.
Medical Editor



My own answering machine is arguing with me!



Physician questions PMS endorsed insurance

To the editor:

Please advise as to the status of the umbrella coverage issued by the Alexander Agency in Pittsburgh. A notice of cancellation has been received.

It would appear that insurance recommended by the Pennsylvania State Medical Society and advertised in PENNSYLVANIA MEDICINE has an extremely poor record. This umbrella policy was endorsed by the Pennsylvania Medical Society and is now being cancelled.

I recall a similar ad for Argonaut Insurance in the

malpractice insurance. The ads implied that the insurance had the approval and endorsement of the Pennsylvania Medical Society. Fortunately, I made no changes in my malpractice program and remained with the Medical Protective Company.

In summary, it would seem that advertising in PENNSYLVANIA MEDICINE has given poor and misleading information to members of the Pennsylvania State Medical Society.

Frederic C. Lechner M.D.
Williamsport

Insurance programs explained

Dear Dr. Lechner:

I am writing in response to your letter of April 18, 1976, relative to your general displeasure with advertising in PENNSYLVANIA MEDICINE, presumably regarding endorsed insurance programs, and specifically, your displeasure with the performance of the personal/professional umbrella coverage and the Argonaut basic professional liability insurance coverage.

You should be aware that the Pennsylvania Medical Society currently endorses thirteen insurance programs, as benefits of PMS membership. The responsibility for the establishment and continuous review of these programs belongs to the Society's Council on Medical Service, and that group reviews enrollment, premium, and loss data on these programs, at least annually. For the large part, the programs have been stable and worthwhile in terms of PMS member benefits. For example, the Society's Disability Income Program, underwritten by the Continental Insurance Company, and administered by the Bertholon-Rowland Agencies, was featured last year in the *Medical Economics* journal as one of the three outstanding programs available to doctors anywhere in the country. In fact, several refinements in this program since that time probably establish the Disability Income Program as second to none and for that reason, over 6,000 PMS members have availed themselves of the coverage.

As another example, the Workmen's Compensation Program, underwritten by the Casualty Recip-

rocal Exchange and administered by the Dodson Insurance Group, has returned 35-40 percent of the actual premium as a policyholder dividend in the three years the program has been in operation.

In other words, I cannot accept your suggestion "... that advertising in PENNSYLVANIA MEDICINE has given poor and misleading information to members of the Pennsylvania Medical Society ..." because the professional liability situation, not only in Pennsylvania, but in the entire United States, has gone sour.

The Pennsylvania Medical Society endorsed a group personal-professional umbrella program with the Reliance Insurance Company at a very competitive premium a number of years ago. At the time that program was endorsed, there was competition in the private market, and the Council on Medical Service endorsed the best program available at the time. Less than two years later, the professional liability crisis became acute and Reliance and dozens of other carriers found they had written a three-year policy at a grossly inadequate rate. From a purely financial management point of view, there is simply no good reason for a company to remain in a line of business which has proved to be a loser. And so, with the marketplace virtually gone, the Society, through the Alexander Agency, searched the marketplace for another facility. The only alternative that was available to us was the Chicago Insurance Company, a member of the Interstate Insurance Group. The premium was not nearly so acceptable

as with Reliance, but it was a coverage that was available to PMS members, if they felt it was necessary.

Pennsylvania physicians no longer need umbrella coverage because Act 111, the "Health Care Services Malpractice Act of 1975," established a Catastrophe Loss Fund to pay awards above \$100,000 per occurrence or \$300,000 annual aggregate.

With respect to the Argonaut situation, I am very pleased that you have your coverage with Medical Protective and that you did not in fact switch your coverage to Argonaut. It may interest you to know that Medical Protective's book of business in Pennsylvania has remained rather static since 1969, when the first professional liability availability problem was recognized. At that time, there were approximately 7,000 PMS members insured with Medical Protective (today, there are approximately 6,500), while there were 12,000 members of the Pennsylvania Medical Society. In 1969 and 1970, insurance companies were stumbling over themselves in their rush to leave the professional liability insurance field and there was simply no market for a large number of PMS members who were being non renewed by dozens of companies. Medical Protective would not accept them; Aetna maintained their approximately 1,500 insureds; and Lloyd's of London was charging extortion rates. The Pennsylvania Medical Society had absolutely no alternative, in my judgment, but to establish a group program which has in fact provided continuous and uninterrupted professional liability coverage since June of 1971 to

physicians who by and large had no other coverage available. Unfortunately, not even insurance experts could have predicted the magnitude of the malpractice crisis when the PMS entered the agreement with the Argonaut Insurance Company. Because of Medical Protective's maintaining its portfolio of low risk physicians, Argonaut has had to deal with a disproportionate mix of high-risk physicians, and as a result, premiums have far surpassed those of Medical Protective. In fact, Argonaut is making every effort to leave Pennsylvania, as it has in the other six states in which it was writing medical professional liability insurance. The Pennsylvania Medical Society has maintained this market for 4,200 members through a court order, which is effective even today. It is certainly not the way we would like to do business, but it appears it is the only way at this point in time.

On July 11, 1976, the PMS House of Delegates decided to support the Board of Trustees' recommendation to establish a physician-owned professional liability insurance company, which we expect would assume the Argonaut book of business. This action is not to our liking, but the alternatives facing the Medical Society are such that there is no other good alternative than for the PMS to enter the underwriting of professional liability insurance.

I trust this information gives you a better understanding of what has transpired with these two programs and why.

David A. Smith, M.D.
Medical Editor



education

This issue carries no education course listings. The September issue will contain a supplement—a comprehensive list of education courses being offered in all parts of Pennsylvania. Consult that issue or write for a copy of the supplement to: Council on Education and Science, Pennsylvania Medical Society, 20 Erford Road, Lemoyne, PA 17043.

When **impotence** due to
androgenic deficiency

is driving them apart



Android® 5 Buccal
Tabs
Android® 10 Oral
Tabs
Android® 25 *
Oral
Tabs

Methyltestosterone N.F. — 5, 10, 25 mg.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosterone-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunichism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** Robert * B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

Android® G

Androgen, Estrogen, Vitamins, Minerals

EACH ANDROID-G TABLET CONTAINS:

Methyltestosterone	1.25 mg
Ethinyl Estradiol	0.005 mg
L-lysine	100 mg
Nicotinic Acid	12.5 mg
Iron (from Ferrous Sulfate)	2.82 mg
Vitamin A	2,500 U.S.P. Units
Vitamin D	250 U.S.P. Units
Thiamine Mononitrate	2.5 mg
Riboflavin	2.5 mg
Ascorbic Acid	25.0 mg
Folic Acid	0.1 mg
Vitamin B-12	1.5 mcg

Methionine	12 mg
Choline Bitartrate	15 mg
Inositol	10 mg
Calcium Pantothenate	2.5 mg
Pyridoxine	0.25 mg
Copper (from Copper Sulfate)	0.25 mg
Zinc (from Zinc Oxide)	0.25 mg
Iodine (from Potassium Iodide)	0.075 mg
Calcium (from Dicalcium Phosphate)	72.5 mg
Phosphorus (from Dicalcium Phosphate)	55 mg
Potassium (from Potassium Sulfate)	2.5 mg
Manganese (from Manganese Sulfate)	0.5 mg
Magnesium (from Magnesium Sulfate)	0.5 mg

**Anabolic Stimulant
Increased Muscular Tone
Osteoporosis**

ACTION AND USES DOSAGE: 1 tablet after breakfast and supper or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. **PRECAUTIONS:** Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. **CONTRAINDICATIONS:** Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. **AVAILABLE:** Bottles of 100 and 500 tablets.



THE BROWN PHARMACEUTICAL CO., INC. 2500 West Sixth Street, Los Angeles, California 90057

Write for Literature and Samples



VISUAL FOCUS ON ACUTE GOUTY ARTHRITIS



Foot of patient with acute gouty arthritis as seen by conventional x-ray.



Scintiphotogram of same foot reflects inflammatory process.

The scintiphotograph on the right shows increased uptake of radiotechnetium polyphosphate in the metatarsophalangeal joint and the proximal interphalangeal

joint of the great toe of a patient with acute gouty arthritis. This increased uptake probably results from increased vascularity in the affected areas.

For a more detailed description of scintiphotography, see "addendum" at right.

THERAPEUTIC FOCUS ON

CAPSULES, 25 mg and 50 mg

INDOCIN[®]

(INDOMETHACIN | MSD)

*helps relieve pain
and other symptoms
of inflammation
in acute
gouty arthritis
in selected patients*

INDOCIN is a potent drug with anti-inflammatory, antipyretic, and analgesic properties. It should not be used in conditions other than those recommended. Although INDOCIN does not alter the progressive course of the underlying disease, in selected patients with acute gouty arthritis it has been found highly effective in relieving pain and in reducing fever, swelling, and tenderness.

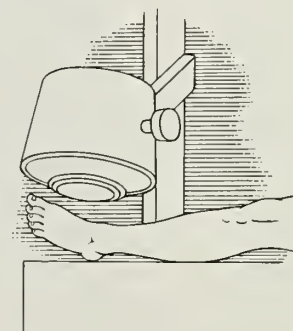
MSD
MERCK
SHARP
&
DOHME

For a brief summary of prescribing information, please see following page.

addendum

MSD
MERCK
SHARP
&
DOHME

Facts about Scintiphotography



In recent years a variety of radiopharmaceuticals have been employed to aid in the diagnosis of bone and joint disorders. The joint-imaging technique consists of injecting technetium polyphosphate intravenously, and imaging is performed with the scintillation camera two hours after the administration of the radionuclide. In general, for joint surveying, the shoulders, elbows, hands, wrists, knees, ankles, feet, and vertebral column are mapped. The entire scanning process takes approximately one hour. The criterion for a positive image is a higher concentration of radioactivity in a joint region than in adjacent nonarticular bone. In effect, each patient serves as his own control.

INDOCIN[®]

(INDOMETHACIN | MSD)



helps relieve pain
and other symptoms
of inflammation
in acute
gouty arthritis
in selected patients

IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considered a simple analgesic and should not be used in conditions other than those recommended. The drug should not be prescribed for children because safe conditions for use have not been established.

Because of the high potency of the drug and the variability of its potential to cause adverse reactions, the following are strongly recommended: 1) the lowest possible effective dose for the individual patient should be prescribed. Increased dosage tends to increase adverse effects, particularly in doses over 150-200 mg per day, without corresponding clinical benefits; 2) careful instructions to, and observations of, the individual patient are essential to the prevention of serious and irreversible, including fatal, adverse reactions, especially in the aging patient.

Contraindications: Children 14 years of age and under; pregnant women and nursing mothers; active gastrointestinal lesions or history of recurrent gastrointestinal lesions; allergy to aspirin or indomethacin.

Warnings: *Gastrointestinal Effects:* Because of the occurrence and, at times, severity of gastrointestinal reactions, be continuously alert for any sign or symptom signaling a possible gastrointestinal reaction. The risks of continuing therapy with INDOCIN in the face of such symptoms must be weighed against the possible benefits to the individual patient. Gastrointestinal effects may be reduced by giving the drug immediately after meals, with food, or with antacids. Use greater care in aging patients.

Ocular Effects: Corneal deposits and retinal disturbances, including those of the macula, have been observed in some patients on prolonged therapy. Discontinue therapy if such changes are observed. Ophthalmologic examination at periodic intervals is desirable in patients on prolonged therapy.

Central Nervous System Effects: INDOCIN may aggravate psychiatric disturbances, epilepsy, and parkinsonism, and should be used with considerable caution in patients with these conditions. If severe CNS adverse reactions develop, discontinue the drug.

Precautions: Blurred vision may be a significant symptom that warrants a thorough ophthalmologic examination. Patients should be cautioned about engaging in activities requiring mental alertness and motor coordination, as driving a car. Headache which persists despite dosage reduction requires complete cessation of the drug. May mask the usual signs and symptoms of infection; therefore, the physician must be continually on the alert for this and should use the drug with extra care in the presence of existing controlled infection. After the acute phase of the disease is under control, an attempt to reduce the daily dose should be made repeatedly until the patient is off entirely.

Drug Interactions: Although INDOCIN has not influenced the hypoprothrombinemia produced by anticoagulants, patients on anticoagulant therapy should be observed closely for alterations in prothrombin time. In patients receiving probenecid, plasma levels of indomethacin are likely to be increased and a lower total daily dose of INDOCIN may produce a therapeutic effect; increases in the dose of INDOCIN should be made cautiously and in small increments.

Adverse Reactions: *Gastrointestinal Reactions:* Single or multiple ulcerations of the esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage, with fatalities in some instances; rarely, intestinal ulceration has been associated with stenosis and obstruction; gastrointestinal bleeding without obvious ulcer formation; perforation of preexisting sigmoid lesions (diverticulum, carcinoma, etc.); rarely, increased abdominal pain in ulcerative colitis patients or development of ulcerative colitis and regional ileitis; gastritis may persist after the cessation of the drug; nausea, vomiting, anorexia, epigastric distress, abdominal pain, and diarrhea.

Eye Reactions: Corneal deposits and retinal disturbances, including those of the macula, have been observed on prolonged therapy; blurring of vision.

Hepatic Reactions: Rarely, toxic hepatitis and jaundice, including some fatal cases.

Hematologic Reactions: Aplastic anemia, hemolytic anemia, bone marrow depression, agranulocytosis, leukopenia, and thrombocytopenic purpura may occur rarely. Since some patients manifest anemia secondary to obvious or occult gastrointestinal bleeding, appropriate blood determinations are recommended.

Hypersensitivity Reactions: Acute respiratory distress, a rapid fall in blood pressure resembling a shock-like state, angioedema, dyspnea, asthma, angitis, pruritus, urticaria, skin rashes, purpura.

Ear Reactions: Hearing disturbances—deafness reported rarely; tinnitus.

Central Nervous System Reactions: Psychic disturbances including psychotic episodes, depersonalization, depression, and mental confusion; coma; convulsions; peripheral neuropathy; drowsiness; lightheadedness; dizziness; syncope; headache.

Cardiovascular-Renal Reactions: Edema, elevation of blood pressure, hematuria.

Dermatologic Reactions: Loss of hair, erythema nodosum.

Miscellaneous: Rarely, vaginal bleeding, hyperglycemia, glycosuria, ulcerative stomatitis, and epistaxis.

Supplied: Capsules containing 25 mg indomethacin each, in single-unit packages of 100 and bottles of 100 and 1000; capsules containing 50 mg indomethacin each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

In vitro susceptibility updated and still virtually unchanged

Schering

A five-year history of pathogen susceptibility to Garamycin® (gentamicin sulfate) — 1971-1975

	1971	1972	1973	1974	1975
Gram-Negative Susceptibility No. of Patient Isolates	98% 89,317	97% 113,473	97% 127,763	97% 150,094	97% 193,626
 <i>Escherichia coli</i>	99%	99%	99%	99%	99%
 <i>Proteus species,</i> indole-negative	98%	99%	99%	99%	99%
 <i>Proteus species,</i> indole-positive	97%	96%	94%	94%	92%
 <i>Pseudomonas</i> <i>aeruginosa</i>	96%	96%	95%	94%	95%
 <i>Klebsiella-</i> <i>Enterobacter-</i> <i>Serratia</i>	99%	98%	99%	99%	98%
Staphylococcal Susceptibility No. of Patient Isolates	97% 6,995	98% 11,109	98% 12,225	99% 18,352	99% 28,130
 <i>Staphylococcus</i> <i>aureus</i>	97%	98%	98%	99%	99%
 <i>Staphylococcus</i> <i>epidermidis</i>	97%	97%	98%	98%	98%

Source: PMR Bacteriologic Reports — 1971-1975.

These *in vitro* data are based on results obtained from a nationwide panel of 180 acute-care hospitals of 100 beds or more. All hospitals in the audit used the Kirby-Bauer method of disc sensitivity. Data are presented in unweighted form.

In vitro susceptibility data are not necessarily indicative of clinical effectiveness.

See *Clinical Considerations* section which follows...

Garamycin® I.M./I.V.
gentamicin sulfate 80mg/2ml.
injectable

40 mg / ml Each ml. contains gentamicin sulfate equivalent to 40 mg. of gentamicin

The seven major gram-negative pathogens and *Staphylococci* remain highly susceptible...

Schering

Of the seven major gram-negative pathogens encountered in the hospital, 97 per cent remained sensitive to Garamycin *in vitro* over a five-year period; 99 per cent of *Staphylococci* remained sensitive.

GARAMYCIN® Injectable, brand of gentamicin sulfate, U.S.P., injection, 40 mg. per ml. Each ml. contains gentamicin sulfate, U.S.P. equivalent to 40 mg. gentamicin.
For Parenteral Administration

WARNING

Patients treated with GARAMYCIN Injectable should be under close clinical observation because of the potential toxicity associated with the use of this drug.

Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment.

Monitoring of renal and eighth nerve function is recommended during therapy of patients with known impairment of renal function. This testing is also recommended in patients with normal renal function at onset of therapy who develop evidence of nitrogen retention (increasing BUN, NPN, creatinine or oliguria). Evidence of ototoxicity requires dosage adjustments or discontinuance of the drug.

In event of overdose or toxic reactions, peritoneal dialysis or hemodialysis will aid in removal of gentamicin from the blood.

Serum concentrations should be monitored when feasible and prolonged concentrations above 12 mcg./ml. should be avoided.

Concurrent use of other neurotoxic and/or nephrotoxic drugs, particularly streptomycin, neomycin, kanamycin, cephaloridine, viomycin, polymyxin B, and polymyxin E (colistin), should be avoided.

The concurrent use of gentamicin with potent diuretics should be avoided, since certain diuretics by themselves may cause ototoxicity. In addition, when administered intravenously, diuretics may cause a rise in gentamicin serum level and potentiate neurotoxicity.

USAGE IN PREGNANCY Safety for use in pregnancy has not been established.

INDICATIONS GARAMYCIN Injectable is indicated, with due regard for relative toxicity of antibiotics, in the treatment of serious infections caused by susceptible strains of the following microorganisms:

Pseudomonas aeruginosa, *Proteus* species (indole-positive and indole-negative), *Escherichia coli* and *Klebsiella-Enterobacter-Serratia* species

Clinical studies have shown GARAMYCIN Injectable to be effective in septicemia and serious infections of the central nervous system (meningitis), urinary tract, respiratory tract, gastrointestinal tract, skin and soft tissue (including burns).

Bacteriologic tests to determine the causative organisms and their susceptibility to gentamicin should be performed.

Bacterial resistance to gentamicin develops slowly in stepwise fashion; there have been no one-step mutations to high resistance.

In suspected or documented gram-negative sepsis, GARAMYCIN may be considered as initial therapy. The decision to continue therapy with this drug should be based on the results of susceptibility tests, the severity of the infection, and the important additional concepts contained in the Warning Box.

For suspected sepsis when the infecting organism is unknown, gentamicin may be administered in conjunction with a penicillin-type drug. Following identification of the organism and its susceptibility, appropriate antibiotic therapy should then be continued. In the neonate with suspected sepsis or staphylococcal pneumonia, a penicillin-type drug is also usually indicated as concomitant therapy with gentamicin.

GARAMYCIN Injectable has been shown to be effective in serious staphylococcal infections. It may be considered in those infections when penicillins or other less potentially toxic drugs are contraindicated and bacterial susceptibility testing and clinical judgment indicate its use.

CONTRAINDICATIONS A history of hypersensitivity to gentamicin is a contraindication to its use.

WARNINGS See Warning Box.

PRECAUTIONS Neuromuscular blockade and respiratory paralysis have been reported in the cat receiving high doses (40 mg./kg.) of gentamicin. The possibility of these phenomena occurring in man should be considered if gentamicin is administered to patients receiving neuromuscular blocking agents, such as succinylcholine and tubocurarine.

Treatment with gentamicin may result in overgrowth of nonsusceptible organisms. If this occurs, appropriate therapy is indicated.

ADVERSE REACTIONS:

Nephrotoxicity: Adverse renal effects, as demonstrated by rising BUN, NPN, serum creatinine and oliguria, have been reported. They occur more frequently in patients with a history of renal impairment treated with larger than recommended dosage.

Neurotoxicity: Adverse effects on both vestibular and auditory branches of the eighth nerve have been reported in patients on high dosage and/or prolonged therapy. Symptoms include dizziness, vertigo, tinnitus, roaring in the ears and hearing loss.

Numbness, skin tingling, muscle twitching, and convulsions have also been reported.

Note: The risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.

Other reported adverse reactions, possibly related to gentamicin, include increased serum transaminase (SGOT, SGPT), increased serum bilirubin, transient hepatomegaly, decreased serum calcium; splenomegaly, anemia, increased and decreased reticulocyte counts, granulocytopenia, agranulocytosis, thrombocytopenia, purpura, fever, rash, itching, urticaria, generalized burning, joint pain, laryngeal edema, nausea, vomiting, headache, increased salivation, lethargy and decreased appetite, weight loss, pulmonary fibrosis, hypotension and hypertension.

DOSAGE AND ADMINISTRATION

GARAMYCIN Injectable may be given intramuscularly or intravenously.

For Intramuscular Administration:

Patients with normal renal function

Adults: The recommended dosage for GARAMYCIN Injectable for patients with serious infections and normal renal function is 3 mg./kg./day, administered in three equal doses every 8 hours.

For patients weighing over 60 kg. (132 lb.), the usual dosage is 80 mg. (2 ml.) three times daily. For patients weighing 60 kg. (132 lb.) or less, the usual dosage is 60 mg. (1.5 ml.) three times daily.

In patients with life-threatening infections, dosages up to 5 mg./kg./day may be administered in three or four equal doses. This dosage should be reduced to 3 mg./kg./day as soon as clinically indicated.

In children and infants, the newborn, and patients with impaired renal function, dosage must be adjusted in accordance with instructions set forth in the Package Insert.

For Intravenous Administration:

The intravenous administration of GARAMYCIN Injectable is recommended in those circumstances when the intramuscular route is not feasible (e.g., patients in shock, with hematologic disorders, with severe burns, or with reduced muscle mass).

For intravenous administration in adults, a single dose of GARAMYCIN Injectable may be diluted in 100 or 200 ml. of sterile normal saline or in a sterile solution of dextrose 5% in water; in infants and children, the volume of diluent should be less. The concentration of gentamicin in solution in both instances should normally not exceed 1 mg./ml. (0.1%). The solution is infused over a period of one to two hours.

The recommended dose for intravenous administration is identical to that recommended for intramuscular use.

GARAMYCIN Injectable should not be physically premixed with other drugs, but should be administered separately in accordance with the recommended route of administration and dosage schedule.

HOW SUPPLIED GARAMYCIN Injectable, 40 mg. per ml., is supplied in 2 ml. (80 mg.) multiple-dose vials and in 1.5 ml. (60 mg.) and 2 ml. (80 mg.) disposable syringes for parenteral administration.

Also available, GARAMYCIN Pediatric Injectable, 10 mg. per ml., supplied in 2 ml. (20 mg.) multiple-dose vials for parenteral administration.

011

JUNE 1977
AHFS Category 8:12.2

For more complete prescribing details, consult Package Insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.

Garamycin® I.M./I.V.
gentamicin sulfate 80mg/2ml.
injectable 40 mg./ml. Each ml. contains gentamicin sulfate equivalent to 40 mg. of gentamicin

WORKS HOUR AFTER
HOUR AFTER HOUR
AFTER HOUR AFTER
HOUR AFTER HOUR
AFTER HOUR AFTER
HOUR AFTER HOUR
AFTER HOUR AFTER
HOUR AFTER HOUR

Tedral[®] SA

Each tablet contains 180 mg anhydrous theophylline (90 mg in the immediate release layer and 90 mg in the sustained release layer); 48 mg ephedrine hydrochloride (16 mg in the immediate release layer and 32 mg in the sustained release layer); 25 mg phenobarbital.

SUSTAINED ACTION

The special long-acting oral bronchodilator...one tablet provides 12 hours of protection...
i.d. dosage offers round-the-clock prophylaxis against asthma symptoms.

Tedral[®] SA Sustained Action — CAUTION: Federal law prohibits dispensing without prescription. *Indications:* Tedral SA is indicated for the symptomatic relief of bronchial asthma, asthmatic bronchitis, and other bronchospastic disorders. It may also be used prophylactically to abort or minimize asthmatic attacks and is of value in managing occasional, seasonal, or perennial asthma. Tedral SA (Sustained Action) offers the convenience of b.i.d. dosage. Tedral SA is an adjunct in the total management of the asthmatic patient. Acute or severe asthmatic attacks may necessitate supplemental therapy with other drugs by inhalation or other parenteral routes. *Contraindications:* Sensitivity to any of the ingredients; pharyngitis. *Warning:* Drowsiness may occur. PHENOBARBITAL MAY BE HABIT-FORMING. *Precautions:* Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma. *Adverse Reactions:* Mild epigastric distress, palpitation, tremulousness, insomnia, difficulty of micturition, and CNS stimulation have been reported. *Dosage:* Tedral SA. *Adults* — (average prophylactic or therapeutic dosage) — one tablet on arising and one tablet 12 hours later. Tablets should not be chewed. *Dosage in children under 12* is not recommended because usage has not been established. *Supplied:* Tedral SA. Double-layered, uncoated, coral/mottled white tablets in bottles of 100 (N 0047-0231-51) and 50 (N 0047-0231-60). Also in unit dose — package of 10 × 10 strips (N 0047-0231-11). Full information is available on request.



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PRESENTS

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SYMPOSIUM**

September 22-24, 1976

Cherry Hill Inn, Cherry Hill, New Jersey

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*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

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Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

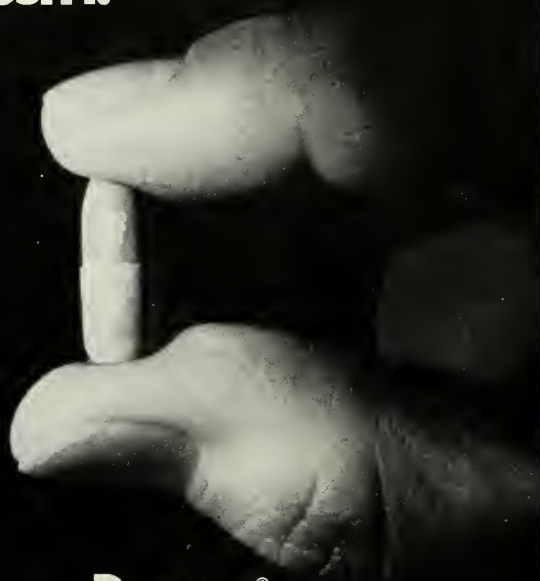
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House of Delegates approves captive insurance company

The Society's House of Delegates, at a special session July 11, in Camp Hill, unanimously approved the formation of a captive professional liability insurance company as approved by the Board of Trustees at the May meeting.

The organization of the Pennsylvania Medical Society Liability Insurance Company is continuing and an additional \$135,000 will be added to the \$15,000 already invested by the Society to purchase the remaining shares of stock in the company, as required by the Insurance Department, as initial capital and surplus.

The officers and Board of Directors are: David S. Masland, M.D., Cumberland County, president; J. Joseph Danyo, M.D., York County, secretary; John F. Rinehan, Society executive vice president, treasurer; A. Reynolds Crane, M.D., Philadelphia County; Henry H. Fetterman, M.D., Lehigh County; Donald E. Harrop, M.D., Chester County; William J. Kelly, M.D., Allegheny County; Robert L. Lasher, M.D.; Erie County; John B. Lovette, M.D.; Cambria County; Matthew Marshall, Jr., M.D., Allegheny County; and George A. Rowland, M.D., Columbia County.

Articles of agreement have

been filed and a certificate of authority has been signed by Governor Milton J. Shapp. Papers have been deposited with Cumberland County Court. The Society's actuaries are developing a rate structure. A complete account of the costs, including necessary capitalization, is expected to be ready at the time of the 1976 Annual Session of the House of Delegates, September 16-18, at the Bellevue-Stratford Hotel in Philadelphia.

Delegates at the special session deferred action on the method of raising the unimpaired surplus required before the company can begin binding insureds until the annual meeting. Delegates also

expressed the desire that the purchase of insurance from the PMS Liability Insurance Company be maintained an exclusive benefit for members of the State Society, and urged that both occurrence and claims made policies be marketed.

David S. Masland, M.D., Society president, keynoted the special session. He said that while formation of a captive company was not a solution to the problem, it would reduce the war from two fronts to one—namely legislative reform. The complete text of Dr. Masland's address will appear in the September issue of PENNSYLVANIA MEDICINE, as will the proceedings of the special session.



DR. MASLAND SPEAKS

MEMBERS OF HOUSE OF DELEGATES LISTEN



Society president elect names council members

William J. Kelly, M.D., Pittsburgh, president elect of the Society, has announced the members of the Society's four administrative councils. The Board of Trustees approved the appointments at the May meeting. The following council members will serve during Dr. Kelly's term as president:

Council on Education and Science—James A. Raub, M.D., chairman (Allegheny); David W. Kistler, M.D., vice chairman, (Luzerne); David P. Connolly, M.D., (Allegheny); Leonard M. Del Vecchio, M.D., (Berks); William E. DeMuth, Jr., M.D., (Cumberland); James B. Donaldson, M.D., (Philadelphia); Frederick D. Fister, M.D., (Lehigh); Arthur H. Hayes, Jr., M.D., (Dauphin); Abram M. Hostetter, M.D., (Lebanon); James J. Houser, M.D., (Venango); Charles L. Leedham, M.D., (Dauphin); David G. Moyer, III, M.D., (Montgomery); Robert N. Moyers, M.D., (Crawford); Paul C. Royce, M.D., (Bradford); Ray G. Sarver, M.D., (Westmoreland); Jacob Schut, M.D., (Philadelphia); Theodore L. Yarboro, M.D., (Mercer); William B. Yeagley, M.D., (Indiana); Nikitas J. Zervanos, M.D., (Lancaster).

Council on Governmental Relations—Donald E. Harrop, M.D., chairman, (Chester); Michael P. Levis, M.D., vice chairman, (Allegheny); R. William Alexander, M.D., (Berks); Thomas W. Bonekemper, M.D., (Montgomery); Frederick G. Brown, M.D., (Montour); Paul A. Cox, M.D., (Cumberland); Herbert Fellerman, M.D., (Luzerne); Philip E. Ingaglio, M.D., (Philadelphia); Thomas J. Kardish, M.D., (Bucks); Lawrence J. Mellon, Jr., M.D., (Delaware); Mario J. Sebastianelli, M.D., (Lackawanna); Bernard B. Zamostien, M.D., (Philadelphia); Charles K. Zug, III, M.D., (Northampton).

Council on Medical Service—Henry H. Fetterman, M.D., chairman, (Lehigh); John J. Danyo, M.D., vice chairman, (York); Joseph V. Caliguiri, M.D., (Allegheny); William R. Dewar, M.D., (Wayne-Pike); Lester A. Dunmire, M.D., (Allegheny); Wayne W. Helmick, M.D., (Beaver); John Helwig, Jr., M.D., (Philadelphia); Webb S. Hersperger, M.D., (Cumberland); Robert L. Lasher, M.D., (Erie); John D. Lane, M.D., (Bucks); J. T. McGeehan, M.D., (Elk-Cameron); John M. Rathgeb, M.D., (Westmoreland); John L. Steigerwalt, M.D., (Montgomery).

Council on Professional Relations and Services—Robert Poole, M.D., chairman, (Chester); David F. Gillum, M.D., vice chairman, (Tioga); Stanley L. Cohen, M.D., (Philadelphia); Donald G. Crawford, M.D., (Dauphin); Samuel S. Faris, M.D., (Montgomery); Robert Laughlin, M.D., (Allegheny); Thaddeus Lekawa, M.D., (York); Roldan Medina, M.D., (Fayette); Stuart E. Price, Jr., M.D., (Allegheny); William A. Shaver, M.D., (Lebanon); Theodore A. Tristan, M.D., (Dauphin). Two vacancies are yet to be filled on this council.

Supplemental Call to the 1976 Annual Session Pennsylvania Medical Society House of Delegates

As directed by Article IX, Section 5 of the Constitution, the Board of Trustees nominates the following members for vacancies on the Judicial Council: For the office now held by Charles K. Rose, Jr., M.D., the Board nominates Charles K. Rose, Jr., M.D., Lehigh County; Rex A. Pittenger, M.D., Allegheny County; and Ralph K. Shields, M.D., Northampton County.

For the office now held by William F. Brennan, M.D. the Board nominates Charles A. Bikle, M.D., Franklin County; H. Thompson Dale, M.D., Centre County; and William A. Limberger, M.D., Chester County.



THE DAUPHIN COUNTY MEDICAL AUXILIARY recently presented a limited edition etching by Harvey Dinnerstein to the State Society in honor of Doctors' Day and the auxiliary's fiftieth anniversary. Mrs. Joseph G. Saxon, center, now immediate past president of the county auxiliary, is shown making the presentation to Society President David S. Masland, M.D., while Mrs. Richard T. Smith, State Society Auxiliary president, looks on.

Society membership increases in '76, nears 14,000

State Society membership as of July 8 totalled 13,854, reflecting an overall increase of 429 over the mid-1975 total.

By the end of March 221 new members had been processed and during the period from April through June the Society added 292 more new members for a total of 513. The total number processed for all of 1975 was 569. At the present rate of growth, total membership is expected to pass the 14,000 mark during 1976.

The State Society launched the Ambassador Membership Recruitment Program in Dauphin and York Counties last September, in Chester County in February, and in Montgomery County in April. The program is scheduled to begin in other counties in the fall. The basis of the program is contact on a one-to-one level to acquaint nonmembers with the advantages of Society membership. At this time the exact impact of the program on membership figures cannot be determined.



MONTGOMERY COUNTY MEDICAL SOCIETY AMBASSADORS

Subpoenas for medical records pose legal dilemma to many

FRED SPEAKER
Harrisburg

There have been increasing reports—particularly from the Philadelphia area—of the mailing of subpoenas to physicians and hospitals, directing the recipient to bring medical records for photocopying. Medical record copy services have sprung up and are available to trial attorneys upon the payment of fees.

A physician receiving one of these mailed subpoenas inquires: "Am I forced under law to comply?"

The answer is almost certainly, "No."

Generally speaking, a sub-

poena of records will be valid only if served in person upon the individual having possession of those records. And in most cases, unless specifically controlled by local rules of court, compliance with a subpoena does not have to be at the court house and may be in private offices. But, despite this answer, in practical terms the subpoena should nonetheless be complied with. It should be kept firmly in mind that even if the mailed subpoenas are legally ineffective, subpoenas properly

Mr. Speaker is associated with the law firm, Pepper, Hamilton, and Sheetz, the Society's legal counsel.

served can do the trick—often with much greater inconvenience and expense to the recipient of the mailed subpoena than would apply if the mailed subpoena were complied with.

If a physician receives a mailed subpoena the following steps are urged:

1. Consult with private counsel to determine the validity of service of the subpoena; and

2. If the service is not valid, consider whether compliance nonetheless should be undertaken because the information may be obtained by a legally valid subpoena and, if so, compliance then will be more costly and time consuming.

In no event should any subpoena be ignored without consideration of the consequences and alternatives.

Society plans new program

Physician patient relations subject of category one meet

The State Society Council on Education and Science has planned a conference on doctor-patient relations, to be held 9:00 a.m. to 3:30 p.m., October 31 at the Holiday Inn, City Line, Philadelphia.

"Why Are Doctors So Misunderstood?" will be the first segment of the conference and will be presented by Ralph Senderowitz, a communications consultant and president of Ralph Senderowitz Associates, Allentown. She will examine the level of doctor-patient communications, demonstrating how easily and often the doctor is misunderstood, and how the patient's emotional reaction may lead to malpractice suits and to dependence on nonprofessionals for medical care.

A. Victor Hansen, M.D., clinical

director of Haverford State Hospital, and author of *Patients Who Trouble You*, will speak on "A Simple Method of Treating Functional Illness," demonstrating a method for treating functional illness of the difficult patient.

"Why Do Our Patients Turn to Quackery?" will be discussed by Stephen Barrett, M.D., Allentown, chairman of the Society Committee on Quackery and a member of the board of directors of the Lehigh Valley Committee Against Health Fraud.

Victor Herbert, M.D., J.D., chief of hematology and nutrition at the Bronx Veterans Administration Hospital and professor at Columbia University College of Physicians and Surgeons, is scheduled to discuss "What the Vitamin Craze Is Doing to Your Patients and the Practice of Medicine."

Finally, Leif C. Beck, LL.B., president of Management Consulting for Professionals, Inc., Bala Cynwyd, will demonstrate "How Efficient Office Management Can Improve Your Patient Relations."

The conference is approved for 5 Category I credits toward the Physician's Recognition Award of the American Medical Association by PMS sponsorship. Advance registration is required; the fee is \$30 and includes a luncheon.

The Society Commission on Accreditation at the June 24 meeting resurveyed and granted full accreditation to the Delaware County Memorial Hospital, Drexel Hill, and Harrisburg Polyclinic Hospital, Harrisburg.

Specialty news

Urologists study advancements, current issues

The Urological Association of Pennsylvania held its annual meeting at the Hotel Hershey in June. The program included scientific presentations, discussions

on current problems facing physicians, and a revision of the organization's bylaws.

David S. Masland, M.D., Society president, spoke on the malprac-

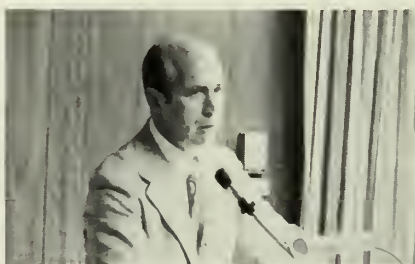
tice insurance situation during the first day's session. Russell B. Roth, M.D., president of the American Association of Clinical Urologists and past president of the American Medical Association, addressed the group on the subject of Uro-Politics 1976.

Scientific segments included a pyelogram conference, and discussions on therapy for carcinoma of the prostate and new concepts and treatment of male infertility.

The following new officers of the association were installed during the President's Banquet: Joseph T. Marconis, M.D., Pottsville, president; Louis Wilkerson, M.D., Drexel Hill, president elect; and Robert Clymer, M.D., West Reading, secretary treasurer. Richard Lyons, M.D., Erie, is the immediate past president.



DR. MARCONIS



DR. MASLAND



UROLOGISTS MEET AT HERSHEY

Psychiatrists' program concerns alternative life styles

Psychiatrists of the Pennsylvania Psychiatric Society continued the theme begun at last year's meeting on sex therapy at the annual meeting held recently at the Pittsburgh Marriott. This year's program dealt with alternative life styles and how they affect the family.

Panelists included noted authorities in divorce law, marriage counseling, and adolescent be-

havior. Over 150 members and their spouses participated in a two-and-one-half day program developed by the Society's Education Committee chaired by Erwin R. Smarr, M.D.

Elected at the society's mem-

bership meeting were the following officers for 1976-77: president, Morton Johan, M.D.; president-elect, William Camp, M.D.; secretary, Richard A. Crandall, M.D.; and treasurer, Joseph O. Strite, M.D.

Surgeons annual meeting draws 187

The first two-day meeting of the Eastern Pennsylvania Chapter, American College of Surgeons, was held May 17-18 at the Sheraton-Valley Forge Hotel in King of Prussia.

One hundred eighty-seven registrants participated in the two-day program, which included na-

tionally and internationally known specialists in surgery. Panel discussions which followed the presentations were active.

The program was planned by the chapter under the direction of George F. Gowen, M.D., president, and Robert A. Buyers, M.D., Program Committee chairman.

GI tract topic of meeting

The Pennsylvania Radiological Society held its 61st Annual Meeting at the Hershey Motor Lodge, May 13-16. This year's program planned by a committee under the direction of Charles Wolfe, M.D., was a refresher on the gastrointestinal tract.

The Society's Annual Oration, presented this year in memory of Richard Chamberlain, M.D., was entitled "Interesting Lesions of the G.I. Tract" and was given by Harold G. Jacobson, M.D., of the Bronx, New York.

Elected were the following officers for 1976-77: president, Ross H. Smith, Jr., M.D.; president elect, Robert B. Funch, M.D.; first vice president, John H. Harris, Jr., M.D.; second vice president, Paul Eyler, M.D.; secretary, Joseph A. Marasco, Jr., M.D.; treasurer, Bernard J. Ostrum, M.D.; and editor, Daniel G. Lareau, M.D.

Internists elect officers

The Pennsylvania Society of Internal Medicine elected officers for 1976-77 during a recent meeting.

The officers are: George F. Hinkens, M.D., Pittsburgh, president; George R. Fisher, M.D., Philadelphia, president elect; Peter N. Hillyer, M.D., Paoli, secretary; and James R. Regan, Bethlehem, treasurer.

Anesthesiologists study emergencies

Emergencies in Anesthesia was the topic of the two-and-one-half day Annual Meeting of the Pennsylvania Society of Anesthesiologists held at the Philadelphia Marriott, May 14-16.

Over 270 anesthesiologists, residents and nurse anesthetists attended the meeting which included discussions on problems of traumas, neurosurgical, and

obstetrical emergencies. The program was developed by a committee chaired by James C. Erickson, III, M.D.

Officers for 1976-77 elected at the membership meeting were: president, Thomas G. Doneker, M.D.; president elect, Stephen C. Finestone, M.D.; secretary, Allen E. Yeakel, M.D.; and treasurer, J. Donald Wentzler, M.D.



THE DAUPHIN COUNTY MEDICAL SOCIETY packed the house recently when Perry D. Shertz, Esq., Wilkes-Barre attorney and member of the Pennsylvania Bar Association's select committee on medical malpractice, spoke to members, wives, and guests. The theme of his address was the need for dialogue between the medical and legal professions. Above, left to right, are Mr. Shertz; Paul F. Kase, M.D., president of the Dauphin County Medical Society; and Thomas F. Fletcher, M.D., program chairman. Other photographs show the audience. Mr. Shertz is preparing an article based on his remarks for future publication in PENNSYLVANIA MEDICINE.

AMA reaffirms position; Pennsylvanians elected

The AMA House of Delegates in June reaffirmed the commitment to counterattack restrictive legislation and voiced opposition to bureaucratic rulemaking, issuing a call for accountability in the regulatory agencies of government.

Pennsylvania's ten delegates and nine of the alternates were present in Dallas as William Y. Rial, M.D., of Swarthmore, was re-elected vice speaker of the AMA House of Delegates and James B. Snow, Jr., M.D., Philadelphia otolaryngologist, was elected to the new Council on Scientific Affairs.

Two resolutions introduced by the Pennsylvania Delegation were adopted in their entirety. The first called for a differentiation between the concepts of health care and medical care in government communications to the public, especially regarding dollars spent. The second called for relief for institutions cited as having violated nursing home fire regulations which have since been invalidated until such time as alternative regulations are adopted. A third resolution, introduced by Matthew Marshall, Jr., M.D., of Allegheny County, also was adopted in its entirety. It establishes a new policy regarding the granting of medical staff privileges to guide the AMA representative to the Joint Commission on Accreditation of Hospitals.

ACMS to host Dr. Salk

Jonas Salk, M.D., is scheduled to deliver the twelfth Nathaniel Bedford Lecture October 27 to the Allegheny County Medical Society.

The lecture was established in 1937 in the memory of Pittsburgh's first practicing physician through a fund set up by the Pittsburgh College of Physicians.



DR. RIAL



DR. SNOW



PENNSYLVANIA'S DELEGATION IN CAUCUS



ALTON I. SUTNICK, M.D., left, dean of the Medical College of Pennsylvania, is the 1976 recipient of the Arnold and Marie Schwartz Award, presented during the opening session of the American Medical Association House of Delegates June 27 in Dallas, Texas. In the photo above, William Y. Rial, M.D., Swarthmore, presents the letter of notification to Dr. Sutnick. Dr. Sutnick was chosen for his work in the areas of lung disease, cancer detection, and antigen research in leukemia, Hodgkin's Disease, and Down's Syndrome.

Society supports state effort to combat A/New Jersey flu

The virus which causes flu in man is constantly changing. Every ten years or so a major antigenic shift occurs; these major changes cause major, worldwide epidemics because the public has not developed antibodies for these new viruses.

The swine flu virus (A/New Jersey) was isolated in February of 1976. Swine flu represents a major change from influenza viruses circulating in the last several years. There is no hard evidence that the A/New Jersey virus in 1976 will equal in virulence the virus causing the 1918-1919 swine flu epidemic with half a million deaths in the United States. There are considerable similarities between the two viruses.

The Pennsylvania Medical Society has endorsed the effort to immunize Pennsylvanians against A/New Jersey flu. The Pennsylvania Department of Health assumes, under federal guidelines, the primary responsibility for distribution of the vaccine and for the actual immunizations at mass immunization sites.

Physicians will be primarily involved through immunizing their private patients. Physicians may charge for the cost of administering the vaccine; they may not charge for the vaccine itself which will be provided free by the Department of Health. Physicians and county medical societies may also be involved in cooperation with the Health Department's County Swine Flu Coordinator in the setting up and running of the swine flu mass immunization sites.

The Department of Health plans to administer the vaccine in two phases. Phase I will run approximately 20 days and be aimed entirely at the high risk population, namely:

- (1) Heart disease of any etiology, particularly with mitral stenosis or congestive heart failure;
- (2) Chronic bronchiopulmonary diseases, such as severe asthma, severe chronic bronchitis, cystic fibrosis, bronchiectasis, tuberculosis, and emphysema;
- (3) Chronic renal failure;
- (4) Diabetes Mellitus; and;
- (5) All persons aged 65 or over.

During Phase I the Department of

Health will concentrate its efforts on such populations as nursing homes, retirement centers, and senior citizens apartments.

As soon as vaccine is available to the Department of Health it will be distributed to the county health center for distribution to physicians. The vaccine will be available to the larger counties first. The vaccine available for Phase I will be a bivalent vaccine containing strains of A/Victorian and A/New Jersey (swine flu).

Phase II will begin as soon as Phase I is completed and run for 60 days. Phase II will be aimed at the remainder of the population. The vaccine available will be a monovalent vaccine for A/New Jersey. Again, as soon as the vaccine is received by the Department of Health, it will be made available through the county health offices to physicians, with the larger counties receiving the first allotments.

Distribution of the vaccine to physicians will be under fairly tight control by the Department of Health for two reasons:

- (1) It now seems that the supply of vaccine available will be less than the amount needed to immunize the entire population, and;
- (2) The vaccine will be available to the Department of Health not all at once, but in smaller batches throughout the immunization period. This means that it is essential that all available vaccine is being used and that significant amounts of vaccine are not stockpiled, either by physicians or by local county health people. It is extremely important that the bivalent vaccine be given only to high-risk patients; otherwise there may not be enough bivalent vaccine for the entire high-risk group.

Physicians will generally be limited to a hundred dose allotment at one time. Before a new allotment is received, the physician must return the consent/data collection form, provided by the Department of Health, with the vaccine. One form must be filled out for each dose given, but the

form can be filled out by the patient or by office personnel. Reporting requirements are mandated by the Department of Health, Education, and Welfare. The data/consent form should be included in the request for a new allotment to the county health office. It is not necessary to wait until all vaccine is gone before ordering more; the physician may choose to reorder when, at his present rate of usage, only a few days' supply remains.

The Department of Health assumes that most orders for vaccine will come from primary care physicians—general practitioners, family physicians, and internists. The role of the pediatrician is unclear because the clinical trials of the vaccine have been inconclusive for younger age groups. Some general surgeons, especially in rural areas, and some OB-GYN physicians will probably order vaccine. Orders for monovalent vaccine from physicians may be discounted by around 25 percent of the total practice on the assumption that 25 percent represents the percentage of the practice composed of younger age groups that will be immunized in the schools or won't be immunized at all. Orders for vaccine in substantial amounts from psychiatrists, radiologists, pathologists, dermatologists, surgical subspecialists, full time hospital based physicians, or full time industrial physicians will be more carefully examined.

The Department of Health immunization program is well organized and is ready to proceed. Two problems have occurred, however, at the federal level. The first problem is the inconclusive results of the clinical trials of the vaccine in the 0 to 23 age group. New trials in this group are being held and will be completed about September 15. There is adequate data that demonstrates that a safe and effective vaccine can be produced for adults.

Second, the liability issue faced in the drug companies has not been resolved; Congress has refused to protect the drug companies from liability for producing the vaccine. Efforts are continuing to resolve this issue. Vaccine will be available 30 days after the

Board Chairman Rowland on flu advisory committee

issue is resolved. Tentatively, vaccine should be available by the last week in August.

The liability question as it relates to physicians is fairly clear. Physicians giving the vaccine in their offices are subject to the usual liability, unless they administer the vaccine at no charge. In that case the physician is exempt from all but gross negligence. The physician who participates in a mass immunization program without pay is also immune from liability except in cases of gross negligence. Under newly passed legislation, county medical societies are also exempt from liability except in cases of gross negligence for participation in the swine flu immunization pro-

gram. An acceptable definition of gross negligence is: "gross negligence would consist of a failure to perform a duty and reckless disregard of the consequences or with such want of care and regard for the consequences as to justify a presumption of willfulness or wantonness. Reasonably exercising his judgment as to whether or not a given action should or should not be taken would not in itself constitute gross negligence . . ." [Williams V. Civil Service Commission].

The Pennsylvania Medical Society is working closely with the Pennsylvania Department of Health on the swine flu immunization program. LeRoy Erickson of the Pennsylvania

Medical Society staff is in regular contact with Health Department staff. George A. Rowland, M.D., chairman of the Pennsylvania Medical Society's Board of Trustees, serves as vice chairman of the Swine Flu Advisory Board which has been set up to advise Secretary of Health Leonard Bachman, M.D., on the program. If you have any questions or desire further information contact LeRoy Erickson at (717) 238-1635.

Additional information including the detailed plan for the swine flu immunization project, legal opinion on the liability issue, and a list of county coordinators, has been mailed to all county medical society secretaries by the Board of Trustees.

Theft of controlled substances must be reported to DEA

Physicians and pharmacists registered with the Drug Enforcement Administration (DEA) are required to report all thefts of controlled substances to the nearest DEA office. Administration officials feel that some physicians and pharmacists may be reporting thefts only to the local police and may not be aware of the requirement. Title 21 of the Code of Federal Regulations, Section 1301.74 requires the registrant to notify the DEA of any theft of controlled substances

upon discovery of the theft or loss.

DEA-106, Report of Theft of Controlled Substances, should be used for reporting a theft or loss. The form not only serves to notify DEA of a theft of controlled substances, but a copy retained by the physician or pharmacist serves as an official record to account for the disposition of the controlled substances. Without this form, the physician or pharmacist may be held responsible for undocumented losses.

Copies of the DEA-106 may be obtained by contacting: the Drug Enforcement Administration office in Philadelphia (600 Arch Street, Room 10224, Philadelphia, PA 19106, telephone [215] 597-9540); or the DEA Pittsburgh office (1000 Liberty Avenue, Room 2306, Pittsburgh, PA 15222, telephone [412] 644-3390).

Maryland state society to meet at Hershey

The semiannual meeting of the Medical and Chirurgical Faculty of the State of Maryland will be held September 10-12 at the Hershey Motor Lodge and Convention Center. Members of the Pennsylvania Medical Society are invited to attend.

No registration fee is required. Room reservations should be made directly with the Hershey Motor Lodge. For more information write John S. Green, III, M.D., chairman, Committee on Program and Arrangements, Medical and Chirurgical Faculty of the State of Maryland, 1211 Cathedral St., Baltimore, MD 21201.

Mental health office youth post filled

H. Allen Handford, M.D., has been appointed director of children and youth services in the State Office of Mental Health.

His responsibilities will include developing, coordinating, and directing the implementation of mental health services for children and adolescents. In addition he will be responsible for establishing standards for children's and adolescents' services, and maintaining a wide range of communication with local, State, and Federal officials.

Dr. Handford has most recently

served as medical director, developmental disabilities, Community Mental Health Center, and clinical assistant professor of psychiatry and human behavior at Jefferson Medical College, Thomas Jefferson University. His professional experience has also included private practice in child and adolescent psychiatry; clinical instructor in child psychiatry and neurological consultant for St. Christopher's Hospital for Children, Philadelphia; director of children's service, Haverford State Hospital.

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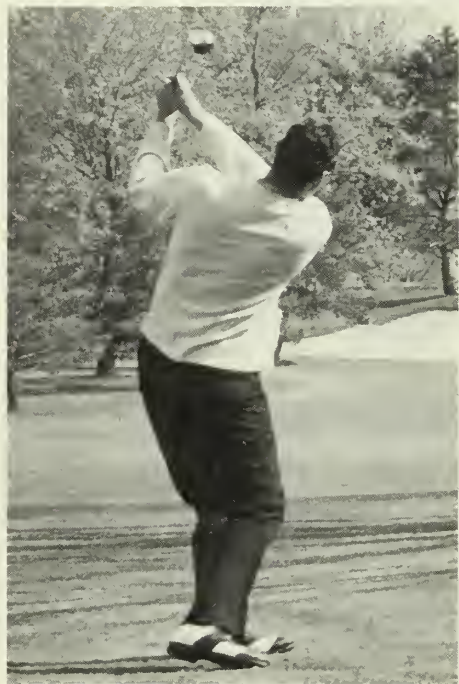
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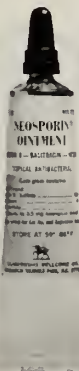
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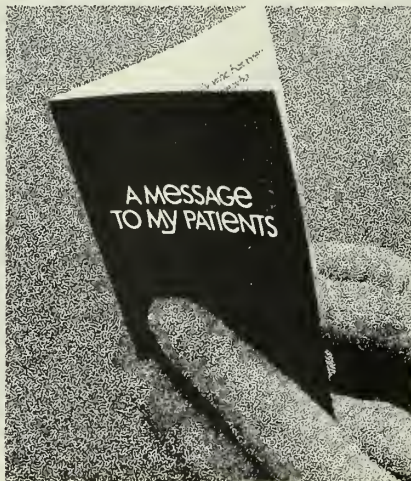
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Common suggestions arising from surveys—part I

LEIF C. BECK, LL.B.

VASILIOS J. KALOGREDIS, J.D.

Bala Cynwyd

While our general "surveys" of medical offices deal with all aspects of clients' practices, the number of areas of common concern surprises us. Accordingly, we have culled a number of common suggestions from reports we have drafted in the past six months in hopes their publication would help all physicians.

A "survey" would involve anywhere from one to six man-days of consultants' time in a medical office. The actual time would, of course, depend on the size of the practice, the number of personnel (both physicians and aides) involved, the complexity of the practice and its problems, and the like. Very large, clinic-sized offices might require still more on-site consultant time.

We hope this series of articles, containing our brief observations, will help practices avoid some common medical office problems.

Personnel matters

Job evaluations and salary reviews—Too many offices have no specific, regularly scheduled procedure for reviewing their aides' job performances. Similarly, many offices routinely grant their personnel periodic pay raises without critically determining how well-deserved they may be. We strongly believe that office personnel should not all receive a standard percentage raise based purely on the increased cost of living.

Various offices have presented us with problems of a difficult or unproductive employee. Too often, that employee has never been told of the dissatisfaction with her work. In such instances, it is obviously difficult for an office to deal with the employee.

Each office should have a regularly scheduled (usually once each year) job evaluation and salary review discussion with each individual employee. At that time, the employee can be told whether the doctor or doctors are satisfied with her work or have criticisms. Job performance can be stressed as the determining factor in setting salaries while informing aides of any upcoming raises. An employee who has not had a satisfactory rating might, knowing the situation, decide either to improve her performance or seek other work—either approach probably beneficial to the office.

Office staff meetings—Many of the surveyed offices rarely have a meeting between all office staff and doctors. Doctors commonly respond that the doctors had such a meeting once or twice, "but they didn't work so we dropped them."

The office staff meetings can be the most helpful way both to develop a team spirit among all employees and to work out specific office problems. Each aide undoubtedly will have certain recommendations for how certain activities can be improved, if only given the chance in a constructive office meeting.

The first couple of office staff meetings are likely to be unsuccessful. It probably takes those meetings to "break the ice" and begin developing a feeling among everyone that the problems can be discussed comfortably and constructively. That is why we urge so many survey clients to resume holding office staff meetings and persevere until they become effective.

Individual job assignments—Small medical offices can suffer from the old idea of having each aide perform all duties. We feel strongly that the aides in such offices must have capacities to perform all work. However, we even more strongly urge that each person have specific responsibility for certain jobs. Even solo practices with two or three employees should reduce to writing each person's specific job assignments.

With such job assignments, an employee will clearly know her responsibilities. Similarly, the employer-doctor will know who to hold responsible for each function's success or failure. The employees' assignments should be broken down into "primary responsibility" and "secondary responsibility." The latter category involves those areas requiring a person's coverage when the primarily responsible person is on vacation, out sick, to lunch, or otherwise occupied. This retains the capacity to adequately cover all jobs in a small office while having special responsibilities.

The principle of job assignments is simple. A person tends to perform work better if she knows what she is responsible to do. Conversely, if everyone is responsible for the jobs, then no one is responsible.

Lunch breaks—A few offices have presented complaints that aides are never able to leave the premises for lunch. Sometimes the doctors contend that the aides are as well served being able to have lunch within the office (sometimes in attractive employee lounges) and therefore should not have to leave the premises. We feel each aide should have the opportunity to take a lunch break and leave the office premises. It provides the person an oppor-

The authors are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd.

tunity to "recharge" her enthusiasm for the job by getting away, even if only for half an hour. In such cases, even if the aide decides to "eat in" it will at least have been her own decision. The level of free choice is important.

Special jobs—Some offices have special patient activities to whom a specific aide is assigned. For example, some pediatric practices have EPSDT clinics, while various internal medicine practices may have a number of blood pressure revisits, special training programs, and the like.

Some offices have assigned a single aide to the special job or jobs in the thought that they can be developed almost without physician involvement. However, the jobs are often far less than full-time since the volume of patients is still small. What often results is a less than fully busy aide, with ill-defined duties for her remaining time and energies.

In such cases, we have encouraged offices to reduce the number of hours during which patients may visit for the special clinics. For instance, if the EPSDT program can be accomplished in two three-hour sessions it is preferable to schedule such work on two specific half-days every week. The responsible aide would then be fully occupied with the EPSDT work on those two time blocks and she could be given primary responsibilities in other areas for the rest of the week. This tends to tighten up that aide's work both to her and the rest of the staff's satisfaction.

Use of physician's assistants—We occasionally visit offices in which the doctors are totally overwhelmed by demands for office time. For example, we know of some busy specialty surgeons who are now finding it almost impossible to schedule office time for postoperative check-ups, routine visits, and new patient visits. They are scheduled for weeks in advance, and it is becoming a problem of properly caring for those patients needing office re-visits.

Although some suggestions can be made with respect to how these offices schedule patients, there comes a point when we must simply concede that the doctors are too busy. The usual solution would then be to recruit and engage an additional physician-member. However, this can be an extremely serious step which might not be proper for the practice or its present members.

Another solution to this dilemma is to recruit and hire a physician's assistant, a trained paramedical person who should have the capacity to perform many of the routine office visit activities. Specialty practices are now able to recruit physician's assistants from a variety of programs, and it is really the only other feasible solution to hiring an additional physician. The secret to physician's assistant work, of course, is extremely well-organized supervision and review by the physician or physicians. Some doctors tend to say their patients would not accept being seen by less than a medical doctor. This objection really need not apply to many circumstances. Particularly when one is dealing with postoperative followups, routine re-checks and the like, we believe any patient group can be educated to the importance of having the work performed by a physician's assistant.

Office facilities

Willingness to move—Too often offices tend to resist

moving to better quarters. The result is inefficiency, less than totally effective medical service, bad business systems and resulting lost income, and general frustration among all doctors and staff. It is not worth these results for such offices to stay put.

Similarly, some doctors practice in offices which cause substantial drains on their time. The primary examples are surgeons with offices far removed from the hospitals they serve even though much more convenient office space might be available. We think any savings in rent are "false savings" in those cases, for the doctor's travel time can be replaced by opportunities to see more patients in the office, greater availability in the hospital, or simply more free time for pleasure.

Philosophy toward building ownership—Some doctors ask us whether they should build and own their medical office facilities. We believe this question is often one of pure economics which can be determined if the doctor or doctors then recognize their two separate rolls—as owner-investors on the one hand and as tenants on the other hand.

We urge these doctors to have very careful mathematical projections prepared of all costs involved in constructing and operating their buildings *before* entering into the transaction. Those projections should build in the opportunity for a 10 percent minimum return on the owner's investment. The result of such a projection should enable one to decide how much rent needs to be paid to produce this kind of return to the owner-investors. If that figure is reasonably comparable with the rent the practice would otherwise have to pay, then ownership might be a good economic step. If, however, the practice must pay considerably higher rent in order to give its doctor or doctors a fair investment return on the building we think the practice and its doctors are generally better off leasing office space and staying out of the real estate business.

Practice budgets

Why, we wonder, does a solo or two-man practice function on such casual business procedures? Even those small practices are probably \$100,000 to \$250,000 businesses which, if anything but medical, would have carefully constructed advance budgets.

We therefore urge some survey clients to establish a budget of their projected income and expenses before each year begins. These numbers are really fairly easy to develop if the doctor or doctors would only give some undivided and conscientious attention to them. There is nothing magic in the system that is beyond the doctors' capacities as "non-business oriented people."

We have recently worked with a couple of good practices in developing their own practice budgets. Those exercises in turn help the doctors decide what salaries they should pay themselves, whether their fee structures were satisfactory, whether they should in fact obtain some equipment they thought would be useful, whether they should recruit and hire another doctor, etc. Decisions like these are too often made in a vacuum. The practice budget procedure can help the doctors make more informed decisions.

Color coding of files

It is a common complaint that a doctor's patient charts are overflowing the available space. Similarly, there are rampant complaints from aides in some offices regarding the inability to locate misfiled charts. Both of these complaints can be minimized if the doctor or practice would simply convert to "color coding" of the patient charts.

Color coding can first help reduce misfiling by assigning separate colors to the first and second letters of each patient's last name. In this manner, any misfiled chart is likely to stand out because of the color discrepancies, and at the same time the colors will provide a much more attractive background for the filing shelves. Similarly, identifying the year a patient has last been seen can be accomplished by applying a colored sticker to the edge of

each chart. Once the stickers have been applied over several years all charts of patients not seen during the intervening years can be pulled in very short order resulting in only "current" charts being left in the active areas.

Both doctors and staff sometimes object that changing their filing systems to color coding would be a horrendously difficult and time-consuming job. This may be true, but charts tend to continue growing at such a pace that sooner or later the job will have to be faced. Under these circumstances, we feel strongly that a practice is well-advised to "bite the bullet" and convert to color coding as soon as possible—no matter how difficult the job may be. Besides, the job usually is not as difficult as anticipated.

These are only a few observations rising from our surveys. More of them will be presented next month. □

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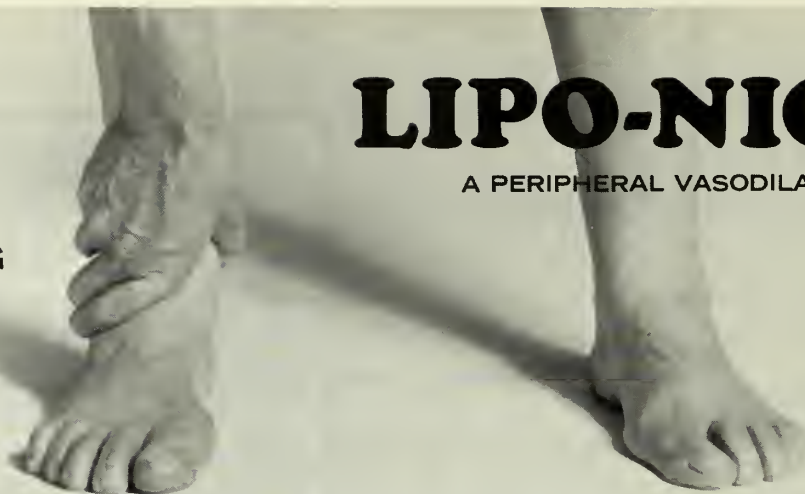
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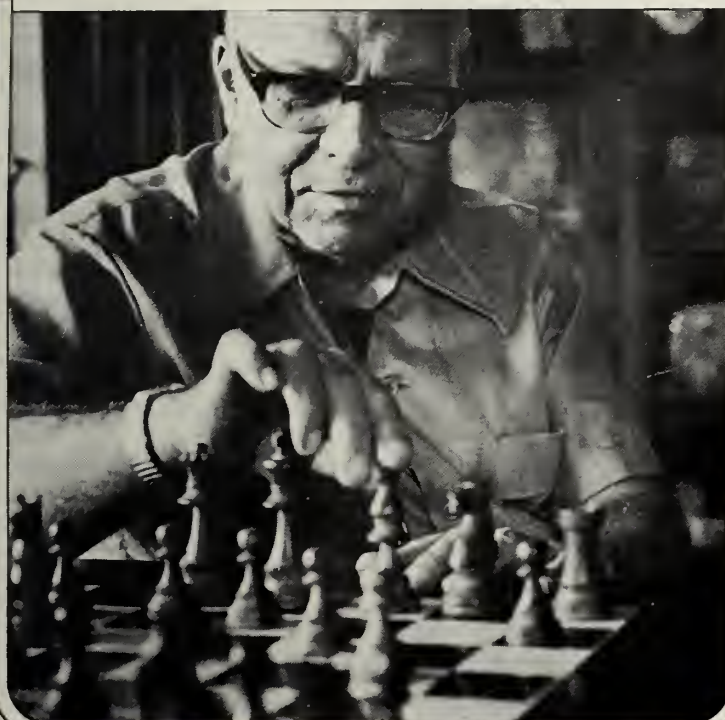
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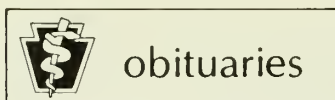
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• **Jesse W. Campbell**, Indiana; Baltimore Medical College, 1909; age 92; died May 7, 1976. He had practiced in Indiana since 1925. His wife, a son, and a daughter survive him.

• **Linfred L. Cooper**, Pittsburgh; University of Pennsylvania School of Medicine, 1909; age 91; died May 6, 1976. His wife and a daughter survive him.

• **Jacob Mayr Danish**, Philadelphia; George Washington University School of Medicine, 1940; age 61; died May 14, 1976. He is survived by his wife, two daughters, and a brother, Abraham Danish, M.D.

• **Percy E. Deckard**, Richfield; Medico-Chirurgical College of Philadelphia, 1904; age 94; died May 14, 1976. Information regarding survivors is unavailable at this writing.

• **Raymen G. Emery**, Washington; University of Pennsylvania School of Medicine, 1924; age 78; died May 8, 1976. Before retiring in 1971, he had practiced in Washington for over 50 years. He was a member of the Philadelphia County Medical Society Board of Censors 1964-65 and on the County Advisory Committee on Medical Assistants 1965-66.

• **Morris H. Jenkins**, Norristown; Temple University School of Medicine, 1926; age 76; died April 24, 1976. He was director of surgery for the Montgomery Hospital 1955-62, and was an active staff member 1926-73. His portrait was hung in the hospital's lobby in honor of his many years of service to the hospital. One brother survives him.

• **Shakir Ilyas**, Munhall; Georgetown University School of Medicine, 1936; age 71; died April 28, 1976. His wife and two daughters survive him.

• **Raymond A. Morris**, Reading; Hahnemann Medical College, 1943; age 66; died May 4, 1976. He was former chief surgical resident at St. Joseph's Hospital and later was on the staff of Community General Hospital. His wife, one son, Wayne R. Morris, M.D., two brothers, and two sisters survive him.

• **Fred J. Phillips**, Quakertown; University of Pennsylvania School of Medicine, 1943; age 56; died May 14, 1976. He was president of the Bucks County Medical Society in 1963 and served on the Board of Directors 1963-65; in addition he had served on the State Society Council on

Governmental Relations and on various county society committees. He is survived by his wife, a daughter, and a brother, William A. Phillips, M.D.

• **Charles F. Schlechter**, Philadelphia; Jefferson Medical College, 1939; age 64; died March 13, 1976. Information regarding survivors is unavailable.

• **Charles R. Wolfe**, Towanda; Temple University School of Medicine, 1955; age 47; died May 16, 1976. He was chief of radiology at Memorial Hospital, Towanda. President of the Bradford County Medical Society in 1965 and 1973, he was a member of the Board of Directors 1963-65, the county Council on Public Service 1964-68, and served on several county society committees. He is survived by his wife, a son, two daughters, his parents, and three sisters.

• **Francis P. Colizzo, Jr.**, Newton, NJ; Hahnemann Medical College, 1962; age 39; died May 6, 1976. His wife, two daughters, two sons, his parents, Dr. and Mrs. Francis P. Colizzo, and a brother survive him.

• **Clyde A. Fitzgerald**, South Fork; Western Pennsylvania Medical College, 1901; age 100; died March 29, 1976. Information regarding survivors is unavailable.

• **Philip Kamin**, Pittsburgh; University of Maryland School of Medicine; age 84; died May 1, 1976. Two daughters and a brother survive him.

• **Harry F. Lower**, Danville; age 26; died April 7, 1976. University of Pittsburgh School of Medicine, 1975; His wife, his parents, Dr. and Mrs. Harold C. Lower, a sister, and a brother survive him.

• **Fred M. Richardson**, Albany, New York; Jefferson Medical College, 1935; age 66; died April 11, 1976. He was former coordinator of professional affairs and chief of the division of general practice for Pennsylvania Hospital, and director of the bureau of medical review for the Empire State Medical Foundation in Albany, New York. He was consultant to the division of medical review for the New York State Health Department until his death. His wife, his mother, and three daughters survive him.

• **Samuel M. Rothermel**, Reading; University of Pennsylvania School of Medicine, 1948; age 51; died April 21, 1976. His father and stepmother survive him.

• **Winslow T. Tompkins**, Gaithersburg, MD; University of Pennsylvania School of Medicine, 1930; age 72; died May 1, 1976. His wife, two daughters, and a son survive him.

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* quotes are from actual member comments. Although minor word changes were made for clarity, content and meaning remain accurate.



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☐ I have heard enough. I am a member of the Pennsylvania Medical Society and please enroll me as a member of the Pennsylvania Medical Cooperative. Enclosed you will find a check in the amount of \$200 to cover the membership requirement. It is my understanding that this is a life-time subscription entitling me to a vote in the affairs of the Cooperative and giving me the right to purchase all medical supplies offered by the Cooperative.

☐ I am impressed by what I have read, but I would like to know more. Please send me more information and a membership application on the Co-op.
(Please make checks payable to the Pennsylvania Medical Cooperative.)

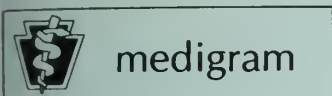
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SEP 17 1976

SOCIETY SEEKS RELIEF FROM ARGONAUT SUIT

The Pennsylvania Medical Society has petitioned Common Pleas Court of Philadelphia to require Argonaut Insurance Company to abide by its court stipulated agreement with the Society to provide professional liability insurance for Society members until December 31, 1979. Judge Stanley M. Greenberg set September 10 as a hearing date on the petition which was filed after Argonaut sued the Society in U.S. District Court of Eastern Pennsylvania July 29. The Argonaut suit claims that the contract was breached when the Society took preliminary steps to establish its captive insurance company. Legal counsel will also go before the U.S. District Court to argue that Common Pleas Court already has jurisdiction in the dispute. Meanwhile, Argonaut's rate increase is pending in the Insurance Department, and Argonaut sent non-renewal notices to 439 physicians, rescinding all but 127 of them several days later. The Society's court action came after Argonaut rejected a settlement proposal of the State Society which would have allowed the company to withdraw after December 31 of this year with the understanding that the captive, the Pennsylvania Medical Liability Insurance Company, would begin operations on January 1, 1977.

BOARD TO RECOMMEND CAPITALIZATION

The Board of Trustees on August 11 voted "to recommend to the House of Delegates that a general assessment of the membership be made as little as possible, not to exceed \$500 per member, in order to fund the captive insurance company, with any additional required funds to be raised through an assessment to participating members joining the company." The amount required by the Pennsylvania Insurance Department to start the company is a minimum of \$6 million.

PENNSYLVANIA DEPARTMENT OF HEALTH
INFLUENZA VACCINE ORDERS AND CERTIFICATION RECORD

SECTION I. (To be filled out by the physician requesting the vaccine)

NAME _____ COUNTY _____
OFFICE ADDRESS _____ OFFICE TELEPHONE _____

Number of Doses Ordered _____ Type Desired Monovalent ☐
Bivalent ☐ Check One Only

Please Read and Sign Below:

I certify that I have received the above ordered number and type of Influenza vaccine doses. I understand I may not charge my patients for the cost of this vaccine, however, I may charge a fee to administer it. Further, I agree to return to the Issuing Office a *Consent Form/Data Sheet* for each dose of vaccine I administer with the knowledge that if I do not, I will not receive additional doses. Finally, I agree to return all the unused and partially used vials of Influenza vaccine when I have completed giving influenza immunizations for the current season.

Is This A Re-Order? Yes ☐
No ☐

Physician's Signature

SECTION II. (To be filled out by the Issuing Office for all orders)

Number Doses Issued _____ Type Mono ☐
BI ☐ Manufacturer _____
Lot Number _____
Issued By _____ Health Center _____
Person's Name _____ Indicate County _____

SECTION III. (To be filled out by Issuing Office for re-orders only)

Number of doses Issued from last order _____ • *Note: These three numbers should agree
Number of Consent Form/Data Sheets returned _____ • before a reorder is granted.
Number of doses still in physician's office _____ •

VACCINE AVAILABLE IN SEPTEMBER

The immunization program against A/New Jersey influenza will get under way in Pennsylvania in late September, Leonard Bachman, M.D., secretary of health, has announced. Congressional approval of an insurance plan for vaccine manufacturers came late, but its signing into law by President Ford has made possible the vaccination of the bulk of the state's population according to readjusted schedules which will be announced shortly. Physicians may obtain the vaccine from their county health offices, using the official request form appearing below. Details appeared in the August issue of PENNSYLVANIA MEDICINE. As stated there, the high risk category of the population will be immunized first, with bivalent vaccine. This group includes those 65 years of age and older and persons of all ages who have such chronic health problems as: (1) heart disease of any etiology; (2) chronic bronchopulmonary disease; (3) chronic renal failure; and (4) diabetes mellitus.

COMMITTEE ON IMPAIRED PHYSICIAN AUTHORIZED

The Board of Trustees on August 11 authorized the President of the Society to appoint an ad hoc committee on the impaired physician to study the problem of physicians afflicted with alcoholism or who are abusers of other drugs and make recommendations for providing such individuals with assistance.

REGIONAL PLANNING SESSIONS SCHEDULED

HSA roundups to be conducted on a regional basis throughout the state were authorized by the Board of Trustees August 11. The Commission on Health Planning will conduct the sessions on Health Systems Agencies, the area planning units being established under P.L. 93-641, the National Health Planning and Resources Development Act. At the same meeting the Board approved a recommendation from the Council on Medical Service that the Commission on Health Planning be reconstituted so that each HSA area in the state is represented.

INSTRUCTIONS FOR COMPLETING THE INFLUENZA VACCINE ORDER AND CERTIFICATION RECORD

SECTION I.

This section is to be filled out by the physician and signed prior to picking up vaccine at the issuing office. The physician's name and address are to be entered in the top left three lines. The county and telephone number should be entered directly to the right of the address. Enter in the space indicated the number of doses desired. Only under unusual circumstances and with proper justification will more than 100 doses be issued at one pick up. Regardless of the amount desired, it should be in multiples of 10. Check the type of vaccine desired, either bivalent for high risk individuals or monovalent for the non high risk. Order only one type of vaccine per order record. Check whether or not this order is a re-order. If it is a re-order you must supply the issuing office a *consent form/data sheet* for each dose administered equaling the amount of your last order. *Sign the form.*

SECTION II.

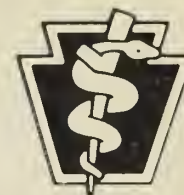
This section is to be filled out by the issuing office for all orders. Indicate the number of doses issued and the type vaccine issued. Copy from the vaccine vial the manufacturer's name and the lot number and write this on the form. The person who issues the vaccine should write his/her name on the form. The county of the issuing office should be indicated also. **Note: Read the instructions in Section I for restrictions on vaccine issuance. Also, review Section I for completeness.**

For each dose of vaccine given, *one consent form* and *one consent form/data sheet* should also be given. The physician should be informed that *one consent form/data sheet* should be returned for each dose given when he reorders.

SECTION III.

This section is to be filled out on *re-orders only*. Check the physician's last order and indicate the number of doses issued. Count the number of *consent form/data sheets* returned with this *re-order*. The three numbers should agree. If they do not, the physician cannot be granted the re-order.

Pennsylvania Medicine



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SEPTEMBER 1976

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RECENT CHANGES

federal register

**Providing
Drug Information
to Physicians**

**Informational
Bulletin #433-76**

**National
Health
Insurance**

special report
**Malpractice
insurance:**

**drug
bulletin**

**Health care doesn't
need more red tape**

**Drug firms challenge
'MAC' rules**

**Drug
Substitution**

**The Canadian Development
of Health Progress
RESEARCH**

Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

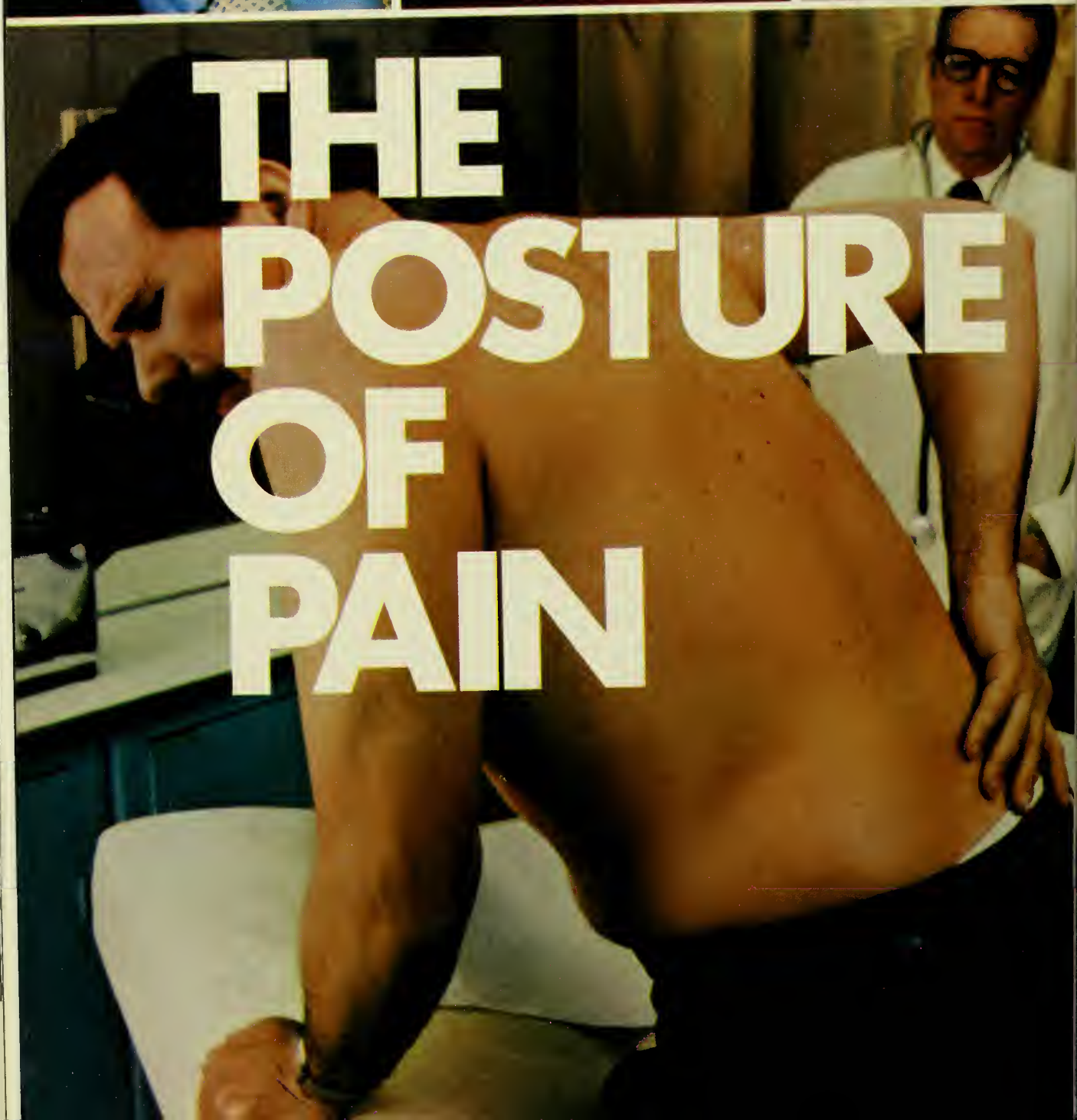
The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
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Indications: Carisoprodol is indicated as an adjunct to rest, physical therapy, and other measures for the relief of discomfort associated with acute, painful musculoskeletal conditions.

Contraindications: Acute intermittent porphyria and allergic or idiosyncratic reactions to carisoprodol or related compounds such as meprobamate, mebutamate, tybamate.

Warnings: *Idiosyncratic Reactions:* Rarely, extreme weakness, transient quadriplegia, dizziness, ataxia, temporary vision loss, diplopia, mydriasis, dysarthria, agitation, euphoria, confusion and disorientation have appeared within minutes or hours of the first dose.

These usually subside in several hours but supportive and symptomatic therapy, including hospitalization, may be necessary.

Pregnancy and Lactation: Safe use not established; weigh potential benefits against potential hazards in pregnancy, nursing mothers (concentrations in breast milk are two to four times that in plasma), or women of childbearing potential.

Children Under Twelve: Not recommended.

Potentially Hazardous Tasks: Driving a motor vehicle or operating machinery.

Additive Effects: Effects of carisoprodol and alcohol, other CNS depressants or psychotropic drugs may be additive.

Drug Dependence: Use cautiously in addiction-prone patients.

Precautions: To avoid excess accumulation, use caution in patients with compromised liver or kidney function.

Adverse Reactions: *Central Nervous System:* Drowsiness, dizziness, vertigo, ataxia, tremor, agitation, irritability, headache, depressive reactions, syncope, insomnia, idiosyncratic reaction (see "Warnings").

Allergic or Idiosyncratic: In previously unexposed patients, these are usually seen after 1-4 doses and include rash, erythema multiforme, pruritus, eosinophilia, fixed drug eruption with cross reaction to meprobamate. Asthmatic episodes, fever, weakness, dizziness, angioneurotic edema, smarting eyes, hypotension and anaphylactoid shock may be manifestations of severe reactions. In such cases, stop carisoprodol and initiate appropriate treatment (e.g., epinephrine, antihistamines, corticosteroids).

Cardiovascular: Tachycardia, postural hypotension, facial flushing.

Gastrointestinal: Nausea, vomiting, hiccup, epigastric distress.

Hematologic: Leukopenia and pancytopenia (on carisoprodol plus other drugs).

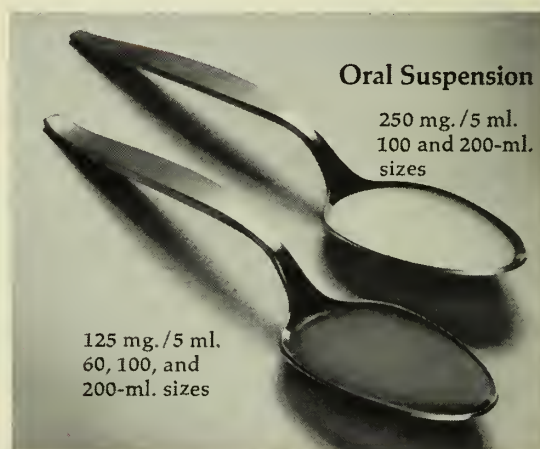
Usual Adult Dosage: One 350 mg tablet three times daily and at bedtime.

Overdosage: Has produced stupor, coma, shock, respiratory depression, and, very rarely, death. The effects of an overdosage of carisoprodol and alcohol or other CNS depressants or psychotropic agents can be additive even when one of the drugs has been taken in the usual recommended dosage. Empty stomach, treat symptomatically; cautiously give respiratory assistance, CNS stimulants, pressor agents as needed. Carisoprodol is metabolized in the liver and excreted by the kidney. Diuresis and dialysis have been used successfully with related drug meprobamate. Carefully monitor urinary output; avoid overhydration; observe for possible relapse due to incomplete gastric emptying and delayed absorption.

Before prescribing, consult package circular or latest PDR information.

Hindle, T.H. III. Calif. Med. 117:7 (Aug.) 1972. 2,3. Unpublished Data on file, Medical Department, Wallace Laboratories, Cranbury, N.J.

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William J. Kelly, M.D., to take president's oath

William J. Kelly, M.D., Pittsburgh internist, becomes the 127th president of the Pennsylvania Medical Society at installation ceremonies on Friday, September 17, 1976, during the annual meeting of the House of Delegates at the Bellevue-Stratford Hotel.

He brings with him experience at all levels in organized medicine as well as with medical education and government's role in relation to the profession.

Dr. Kelly served as president of the Allegheny County Medical Society in 1965, after having served as vice president in 1963 and president elect in 1964. Preceding his elevation to these posts he served the county society in a number of capacities, and for ten years was a delegate to the State Society's House of Delegates, until his election as Tenth District trustee and councilor in 1967.

He was elected vice president of the State Society in 1974. Prior to serving as vice president and then as president elect in 1975, Dr. Kelly was active on a number of PMS councils and committees, including the Council on Governmental Relations, the Committee on Constitution and Bylaws, the Committee on Discipline, the Publication Committee, the Benjamin Rush Committee, the Finance Committee, the Board's Executive Committee, and the ad hoc committee on malpractice insurance.

In 1972 he was elected an alternate delegate to the AMA House of Delegates, and in 1974 was

elected delegate, a position he holds presently.

He began his experience with



government in May 1969, when he was appointed to the State Board of Medical Education and Licensure. He was named chairman of the State Board in 1974.

An associate fellow of both the American College of Physicians and the American College of Cardiology, Dr. Kelly is a member of the Pittsburgh Academy of Medicine and the Pennsylvania Society of Internal Medicine, of which he was president in 1970-71.

Dr. Kelly received his medical degree at St. Louis University School of Medicine in 1947 after completing undergraduate studies at John Carroll University, Cleveland, Ohio. He served his internship at St. Elizabeth's Hospi-

tal, Youngstown, Ohio, and began a residency in medicine there. In September of 1949 he entered the United States Navy and served as assistant force medical officer for the Atlantic Destroyer Force. Following his discharge in 1951, Dr. Kelly resumed his residency in medicine at St. Francis General Hospital, Pittsburgh, an institution with which he has had close ties throughout his professional career. He is a senior staff member at St. Francis and currently is serving as president of the medical staff.

In 1953, Dr. Kelly became clinical instructor of medicine at the University of Pittsburgh School of Medicine. Since 1970 he has been assistant clinical professor of pharmacology at the University of Pittsburgh School of Pharmacy.

Dr. Kelly has had an abiding interest in sports, particularly football. He has served for many years as team physician for a Pittsburgh high school football team. He is a member of the Pittsburgh Athletic Association and lists boating and fishing as other hobbies.

Married in 1944, Dr. Kelly and his wife, Jean, have seven children: Kathleen Marie, Timothy Lannon, Sean Michael, Patrick Kevin, Karen Ann, Colleen Ann, and Ted Daniel.

As Dr. Kelly is installed as president, John V. Blady, M.D., of Philadelphia, currently the Society's vice president, will automatically become president elect. On Saturday, delegates will elect a new vice president, thus insuring the chain of command.

Society delegates invited to Bicentennial lecture

The effects of the use of nuclear weapons on Hiroshima and Nagasaki will be the topic discussed September 15 by Stuart C. Finch, M.D., chief scientist for the Radiation Effects Research Foundation, Hiroshima, 5:30 p.m. at the Bellevue-Stratford Hotel, Philadelphia. The lecture is scheduled as part of "World Health in Human Perspective," a series of Bicentennial lectures presented throughout the year and sponsored by the College of Physicians of Philadelphia and the SmithKline Corporation. Subjects have ranged from health care in colonial times to contemporary problems of population, nutrition, and energy.

On October 6, at 5:30 p.m., in Mitchell Hall of the College of Physicians of Philadelphia, a panel discussion on health considerations will be presented by Victor P. Bond, M.D., Ph.D., associate laboratory director of Brookhaven National Laboratory; Cyril L. Comar, Ph.D., director, Environmental Assessment Department, Electric Power Research Institute; and Wilson K. Talley, Ph.D., assistant administrator for research and development, U.S. Environmental Protection Agency.

The final lecture of the series will be on "the vision" of health and well-being, presented by Kenneth L. Vaux, Dr. Theo., professor of ethics and theology at the Institute of Religion and Human Development and Baylor College of Medicine. He will lecture at 5:30 p.m. in Mitchell Hall of the College of Physicians.

Lectures presented earlier in the year were: health care in colonial times, by historian Alistair Cooke; U.S. nutrition policy for the 1970s, by nutritionist Jean Mayer, Ph.D.; the American way of consumption, by environ-

mentalist Paul Ehrlich, Ph.D.; adapting to the future, by microbiologist Reneé Dubos, Ph.D.; moral development in American children, by research psychiatrist Robert Coles, M.D.; implications of advances in genetics, by Harry

Harris, M.D., professor of human genetics at University College, London; and government in health care, by Philip H. Abelson, Ph.D., president of the Carnegie Institution, Washington, and editor of *Science* magazine.

Dr. Oglesby to address prayer breakfast

Dr. William Barr Oglesby, Jr., professor of pastoral counseling at Union Theological Seminary in Richmond, Virginia, will be the guest speaker at the fourth annual prayer breakfast sponsored by the Committee on Medicine, Religion, and Bioethics, to be held at 8 a.m., Thursday, November 4, at the Host Inn, Harrisburg.

Dr. Oglesby, who has authored such publications as *With Wings as Eagles*, *Referral in Pastoral Counseling*, and *The New Shape of Pastoral Theology*, is recognized as one of the country's lead-

ing authorities on pastoral counseling. He will speak on the subject, "Pastoral Counseling in the Light of New Medical Technology." Dr. Oglesby believes the capacity we now have to prolong life, do genetic manipulation, and the like, poses many issues of a moral and spiritual nature which must be faced.

All members of the Pennsylvania Medical Society, their spouses, and other interested persons are invited to attend. The cost is \$5.00 per person. Contact Kay Mundis at Society Headquarters for reservations.



STATE SOCIETY MEMBERS who insure against workmen's compensation claims with the Dodson Insurance Group, the Society endorsed program, have received a 42.5 percent refund on their premium and will share \$27,171.80. Ronald M. Bachman, director of economic affairs for the Society, is shown above leafing through the refund checks which were mailed in August. The program returned savings of 35 and 40 percent in 1974 and 1975 respectively. Returns on the annual premium are based on the cost of claims of those insured. Further information on the program, which is open to all members of the State Society, is available from Bachman.

House of Delegates meets in Philadelphia

The State Society's Annual Session of the House of Delegates is scheduled to be held September 15-18 at the Bellevue-Stratford Hotel in Philadelphia.

A highlight of the session's activities will be the 29th Annual State Dinner Friday evening, September 17. During the dinner William J. Kelly, M.D., of Pittsburgh, will be installed as the 127th President of the Society, David S. Masland, M.D., will receive the Past President's Medallion, and John P. Hubbard, M.D., will receive the Society's Distinguished Service Award.

Elections will be held Saturday morning. Offices to be filled are: vice president, secretary, speaker of the House of Delegates, vice speaker, two members of the Judicial Council, district censors, delegates and alternates to the AMA, and trustees from the Second, Eighth, and Eleventh Councilor Districts.

Wednesday evening's preliminary activities will include a lecture in the Rose Garden on a 30 year followup of Hiroshima-Nagasaki, the past presidents'

FMG society formed

The newly organized American College of International Physicians, composed of licensed practicing physicians who are graduates of medical schools outside of the United States, will hold its first annual convention, scientific session, and convocation of fellows, in Chicago, October 16-17, 1976.

Further information and requests for application forms and reservation forms for the meeting can be obtained from the College Offices, at Suite 12, 3030 Lake Avenue, Fort Wayne, Indiana 46805 in care of Antonio B. Dones, M.D., President.

dinner in the Blue Room, and the past presidents' wives dinner in the Gold Room.

The House of Delegates are scheduled to meet in the Grand Ballroom at 1:00 p.m., Thursday, following the reference committee chairmen's luncheon at noon. Separate reference committee meetings are scheduled to begin at 3:00 p.m.

Councilor District caucuses will be held Friday morning beginning at 10:30. At 1:00 p.m. will be the second session of the House. The

Pennsylvanian named U.S. hospital head

Ulysses E. Watson, M.D., superintendent of Eastern Pennsylvania Psychiatric Institute, Philadelphia, has been selected to head Saint Elizabeths Hospital, Washington, D.C., the largest



DR. WATSON

federally operated hospital for the mentally ill.

In announcing the appointment, Bertram S. Brown, M.D., director of the National Institute of Mental Health, called Dr. Watson "a man of exceptionally brilliant

State Dinner Reception, courtesy of Frank B. Hall & Co. of Pennsylvania, Inc., will be held at 7:00 p.m. followed by the State Dinner at 8:00. Society elections will begin at 7:30 a.m., Saturday, in the elevator foyer-first convention floor. Following Councilor District caucuses the House will meet for their third session in the Grand Ballroom.

The Board of Trustees and Councilors will meet in the Tecumseh Room after the House adjourns Saturday.

qualifications both in psychiatry and in top-level administrative responsibility." Evidence of his ability is his service "as director of Eastern State Psychiatric Institute, where he had complete responsibility for the organization and direction of an urban institution mandated legislatively to provide leadership for the Commonwealth of Pennsylvania in mental health, research, training, and services."

While director of the Philadelphia hospital, Dr. Watson was assistant deputy secretary for research and training of the Pennsylvania Office of Mental Health and Medical Services. The task involved the creation of a State Bureau of Research and Training, and the coordination, evaluation, and monitoring of the entire research and training program in mental health for the Commonwealth.

Since 1968 Dr. Watson has been secretary of the Montgomery County Medical Society and secretary of the county society's Board of Trustees since 1972. He is chairman of the Montgomery County Delegation to the Pennsylvania Medical Society and is a member of the Pennsylvania Medical Cooperative Board of Directors.

Drs. Farrar, Scheie receive Strittmatter awards

Two distinguished physicians, George E. Farrar, Jr., M.D., and Harold G. Scheie, M.D., received the Philadelphia County Medical Society's Strittmatter Award for their many accomplishments in medicine.

Currently director of medical affairs, *Excerpta Medica*, Princeton, New Jersey, Dr. Farrar is former clinical professor of medicine at Temple University School of Medicine and special lecturer in pharmacology at the Medical College of Pennsylvania. From 1940 to 1971 he had been associated with Wyeth Laboratories, where he became medical director in 1949 and director of medical services in 1962. Prior

to his association with Wyeth, Dr. Farrar had served as assistant professor of medicine at Temple. Before moving to Philadelphia in 1936, he was an associate pharmacologist for the Food and Drug Administration. He served as associate editor of the *Dispensatory of the U. S.* from 1940 to 1960 and a vice president of the U. S. Pharmacopeia Convention from 1970 to 1975.

Dr. Farrar was born in Winter Park, Florida. He graduated with a B.S. degree from the Wesleyan University in 1927 and an M.D. degree from Johns Hopkins University School of Medicine in 1931.

Dr. Farrar has long been active in organized medicine. He is a past president of the Philadelphia County and State Societies and currently serves on the State Society's Judicial Council.

Dr. Scheie, born in Brookings County, South Dakota, obtained a B.S. degree in 1931 and an M.D.

degree in 1935 from the University of Minnesota. He served his internship and residency at the Hospital of the University of Pennsylvania, during which time he earned a D.Sc. degree. In 1953 Dr. Scheie was named professor of ophthalmology in the school of medicine and in the graduate school of medicine in 1956. In 1960 he was named William F. Norris and George E. DeSchweinitz Professor of Ophthalmology, a title which he held for 15 years.

Currently a visiting professor at Hahnemann Medical College and Hospital, he has been director of the Scheie Eye Institute at Presbyterian-University of Pennsylvania Medical Center since 1972.

Dr. Scheie has published extensively and has served on the editorial boards of *Contemporary Surgery*, the *Archives of Ophthalmology*, and the *Journal of Pediatric Ophthalmology*.

Conference to study PA role in practice

A conference in "Assessment and Evaluation of Problems in Primary Care" is scheduled to be held October 2 and 3 at the Penn Harris Motor Inn, Camp Hill.

The conference will be hosted by the Pennsylvania Society of Physician's Assistants and sponsored by the Pennsylvania State University Physician Assistant Program, George Washington University Physician Assistant Program, the Health and Education Council's Community Center for Continuing Education, and Essex Community College.

The conference has been approved for 18 Category I credits toward the Physician's Recognition Award of the American Medical Association and 1.8 continuing education units for nurse practitioners. For more information contact Kenneth R. Harbert, PA-C, Chairman, Continuing Education, Pennsylvania State University Physician Assistant Program, Western Psychiatric Institute and Clinic, 3811 O'Hara St., Pittsburgh, PA 15261.



A. REYNOLDS CRANE, M.D., right, Society immediate past president, installs the officers of the Pennsylvania Society, American Association of Medical Assistants, who are, left to right: Virginia Dougherty, CMA-A, vice speaker of the house; Jacqueline Fehling, speaker of the house; Dorothy A. Taylor, CMA-A, president; Barbara Hodnick, vice president; Sandra Butkowski, CMA-AC, president elect; Sharon Wieder, recording secretary; and Helen Mountjoy, CMA, treasurer. The installation was part of the organization's annual meeting held in May at the Pocono Manor Inn.

Put medicaid under health department, Society says

The Pennsylvania Medical Society called for corrective legislation to assure medical assistance recipients of quality medical care at a hearing before the House of Representatives Subcommittee on Health in Harrisburg July 22.

Henry H. Fetterman, M.D., of Allentown, chairman of the Council on Medical Service, presented the Society's statement at the first of three public hearings on the medicaid program. He told committee members that crisis intervention in the medical assistance program, such as the recent emergency appropriation of \$32 million, is an inappropriate solution to an ever recurring problem.

In calling for corrective legislation he said, "... the current payment of \$6.00 per office visit is grossly inadequate ... coupled with excessive paperwork and long delay in payment (it) will discourage physicians from participating in the program."

He called the posture of the Department of Public Welfare "counterproductive" because it forces medicaid patients into hospital emergency rooms and outpatient clinics where "costs are staggering in comparison with costs in a physician's office."

Dr. Fetterman reminded the committee that since 1967 the State Society has recommended that the Department of Health be designated the single state agency for Title XIX (medicaid)

Chester course listed

The Chester County Medical Society, Chester County Hospital, and Paoli Memorial Hospital plan to hold a basic science review on "Genes, Proteins, and Disease in 1976" Wednesday, October 27, 1:30 to 5:30 p.m. at Paoli Memorial Hospital.

Scheduled speakers are Laird G. Jackson, M.D., associate professor of medicine and chief of



DR. FETTERMAN answered questions posed by Health Subcommittee members following his formal statement. With him, center, are John F. Rineman, executive vice president, and Ronald M. Bachman, director of economic affairs.

and be responsible for supervising the quality and availability of medical care, utilization and med-

ical audit procedures, medical fees, and all matters that relate specifically to medical care.

Surgeon writes history

Louis A. Meier, M.D., Norristown, has written a history that is different from most material generated by the nation's bicentennial celebration. It is called *Early Pennsylvania Medicine, A Representative Early American Medical History*, and deals with the practice of medicine from 1682 to 1799 in what is now Montgomery County.

Dr. Meier's history focuses on those physicians who were "representative of the profession at large," as he states in the preface to the book. "The prevailing tone of the profession is set by those practitioners who provide the greatest amount of medical care.

the division of medical genetics for Thomas Jefferson University, and Eugene Grebner, Ph.D., research assistant professor of medicine in the division of medical genetics at Jefferson. Category I credit has been granted for the program.

For further information contact: Mrs. Beverly Laster, Medical Staff Secretary, Paoli Memorial Hospital, Paoli, PA 19301; (215) 647-2200, ext. 257.

Any medical history which is to give a true reflection of the profession must include the often omitted bulk of the practitioners."

In ten chapters Dr. Meier discusses early Quaker doctors, such as Dr. Edward Jones who arrived in 1682 with Penn, Dr. Thomas Wynne, and Dr. Griffith Owen; doctors to the carriage trade, such as Dr. Thomas Graeme and Dr. Archibald McClean, Jr.; the Schwenkfelder doctors, including Dr. Melchior Heebner and Dr. Abraham Wagner; Dr. John Adolph Meyer, the Moravian physician to whom the book is dedicated; early Pennsylvania and Pennsylvania-German medicine; medicine during the American Revolution including the most complete list ever published of medical men who contributed to the American Revolution; and many individual practitioners in the area during the years 1682-1799.

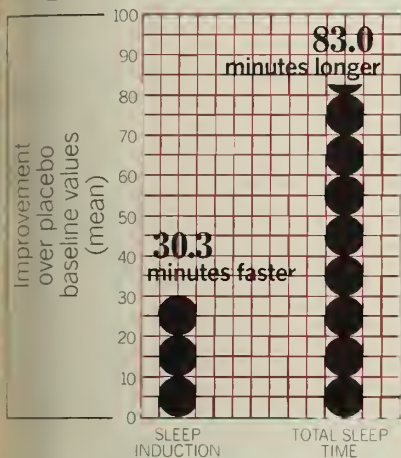
Dr. Meier who is a general surgeon in Norristown earned a bachelor of arts degree from Ohio Wesleyan University and degrees of doctor of medicine and master of surgery from McGill University Faculty of Medicine, Montreal.

The ultimate objective test: sleep laboratory proof of effectiveness... now in geriatric insomnia patients

Six female insomniacs, ranging in age from 67 to 82 years, received Dalmane (flurazepam HCl) for seven consecutive nights in the sleep research laboratory.¹ Improvement over pre-treatment baseline levels was significant for sleep induction and sleep maintenance ($p < .05$). And the greater the sleep problem in these patients, the better the effect with Dalmane (significant correlation at $p < .01$ level).



Elderly insomniacs fell asleep faster, slept longer¹



Results expand and confirm objective proof of efficacy in younger adults with insomnia

The effectiveness of Dalmane (flurazepam HCl) was demonstrated in earlier studies of 32 younger adults with trouble falling asleep, staying asleep or sleeping long enough.² On average, in these studies, Dalmane induced sleep within 17 minutes and provided 7 to 8 hours of sleep, at the same time reducing number of nighttime awakenings.

Relative safety, even in patients on warfarin

Morning "hang-over" has been relatively infrequent with Dalmane. And no unacceptable fluctuation in prothrombin time has been reported in warfarin patients on Dalmane.^{2,3} The usual adult dosage is 30 mg h.s.; in elderly and debilitated patients, limit initial dosage to 15 mg to help preclude oversedation, dizziness or ataxia.

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and

falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

REFERENCES:

1. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
3. Robinson DS, Amidon EL: Interaction of benzodiazepines with warfarin in man, in *The Benzodiazepines*, edited by Garattini S, Mussini E, Randall LO. New York, Raven Press, 1973, p. 641

New evidence proves insomnia relief in elderly patients

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One 30-mg capsule h.s.—usual adult dosage (15 mg may suffice in some patients).

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*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

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Each tablet contains 180 mg anhydrous theophylline (90 mg in the immediate release layer and 90 mg in the sustained release layer); 48 mg ephedrine hydrochloride (16 mg in the immediate release layer and 32 mg in the sustained release layer); 25 mg phenobarbital.

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The special long-acting oral bronchodilator...one tablet provides 12 hours of protection... b.i.d. dosage offers round-the-clock prophylaxis against asthma symptoms.

TEDRAL[®] SA Sustained Action — CAUTION: Federal law prohibits dispensing without prescription. **Indications:** Tedral SA is indicated for the symptomatic relief of bronchial asthma, asthmatic bronchitis, and other bronchospastic disorders. It may also be used prophylactically to abort or minimize asthmatic attacks and is of value in managing occasional, seasonal, or perennial asthma. Tedral SA (Sustained Action) offers the convenience of b.i.d. dosage. Tedral SA is an adjunct in the total management of the asthmatic patient. Acute or severe asthmatic attacks may necessitate supplemental therapy with other drugs by inhalation or other parenteral routes. **Contraindications:** Sensitivity to any of the ingredients; porphyria. **Warning:** Drowsiness may occur. PHENOBARBITAL MAY BE HABIT-FORMING. **Precautions:** Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma. **Adverse Reactions:** Mild epigastric distress, palpitation, tremulousness, insomnia, difficulty of micturition, and CNS stimulation have been reported. **Dosage:** Tedral SA. **Adults** — (average prophylactic or therapeutic dosage) — one tablet on arising and one tablet 12 hours later. Tablets should not be chewed. **Dosage in children under 12** is not recommended because usage has not been established. **Supplied:** Tedral SA. Double-layered, uncoated, coral/mottled white tablets in bottles of 100 (N 0047-0231-51) and 1000 (N 0047-0231-60). Also in unit dose — package of 10 × 10 strips (N 0047-0231-11). Full information is available on request.



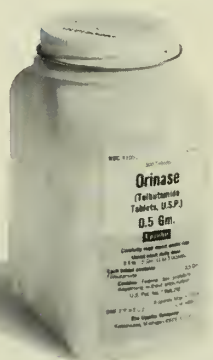
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You may wish to advise your patients that this change is taking place.

ACR states breast cancer policy

The American College of Radiology's Commission on Cancer recently released the following interim statement on breast cancer diagnosis:

Mammography has proven to be the most effective diagnostic tool so far developed for the detection of breast cancer at an early stage before it spreads to regional lymph nodes. This early detection increases the probability of cure. Mammography at appropriate intervals in asymptomatic women over age 35 promises to reduce significantly the number of deaths from breast cancer.

Since there is now no definitive scientific evidence with regard to: (1) optimal age for the initial mammogram, (2) frequency of examination, or (3) data on possible long term radiation risk, this statement is being issued as a summary of current informed opinion.

Care of women with symptoms

In women who have symptoms or physical findings suggestive of possible breast cancer, medical decisions must be individualized to fit the patient's needs. Under these circumstances, mammography is an integral part of the evaluation of the patient.

Screening

Recognizing that definitive data are not yet available that allow the establishment of firm criteria that define a protocol for the screening for breast cancer in asymptomatic women, the ACR recommends the following:

1. All women should have annual physical examination of the breasts and be taught breast self-examination.

2. For asymptomatic women the first, or baseline, mammographic examination should be

performed between the ages of 35 and 40.

3. Subsequent mammographic examinations should be performed at one to three year intervals unless more frequent examination is medically warranted.

4. After age 50, annual or other regular interval examinations, including mammography, should be performed.

5. Although the carcinogenic effects of radiation at current levels of exposure are probably immeasurably small, continuing attempts to reduce exposure should be made. However, image quality must be preserved for accurate diagnosis to insure the best risk/benefit (cure) ratio.

6. Each radiologist should assure the periodic monitoring of his equipment and procedures to determine that the patient's exposure is being maintained at the lowest feasible level.

Research programs

The protocol currently being followed by the NCI/ACS sponsored "Breast Cancer Detection Demonstration Projects" should be pursued so that the data are as complete and accurate as possible in order that meaningful conclusions can be drawn. Followup of the patients must be carried out for a number of years to insure collection and evaluation of the data. Theoretical concerns of possible radiation induced breast cancer do not warrant change in the current protocol of the "Breast Cancer Detection Demonstration Projects." Estimates of risk that include a radiation carcinogenic effect are of dubious validity because of the lack of objective scientific evidence. Research must be continued and encouraged to:

1. Improve methods for meas-

urement of low level radiation;

2. Further reduce the radiation dose in mammography consistent with good image quality;

3. Determine the most appropriate age at which to begin screening for different risk groups;

4. Define women of high risk;

5. Define those mammographic findings that dictate re-examination at a shorter interval;

6. Establish the appropriate intervals for re-examination; and

7. Collect evidence of the benefits and risks of mammography.

Future statements

Further statements will be issued when additional valid information permits.

For more information about this position paper, please call or write to: Gerald D. Dodd, M.D., M.D. Anderson Hospital, 6723 Bertner Dr., Houston, TX 77025; (713) 792-2700; or Richard G. Lester, M.D., Herman Hospital, University of Texas Medical School, Department of Radiology, Houston, TX 77025; (713) 797-3664.

Tumor clinic elects

The forty-sixth annual meeting of the Wainwright Tumor Clinic was held May 12 in Bethlehem. Outgoing president George R. Greenwood, M.D., Bethlehem, presided.

New officers elected during the meeting are the following: Kenneth K. Meyer, M.D., Sayre, president; Alan W. Shriver, M.D., Greensburg, president elect; Richard C. Putnam, M.D., Philadelphia, vice president; John F. Kennard, M.D., Clearfield, treasurer; and James S. Furnary, M.D., Johnstown, secretary.

Directors elected for three year terms are: V. P. Pisula, M.D., Hanover; Russell R. Tyson, M.D., West Chester; and Franklin G. Wade, M.D., Williamsport.

State pediatricians to study problems of infancy

The Pennsylvania Chapter, American Academy of Pediatrics plans to sponsor a seminar in pediatrics November 5-7 at the Dorado Beach Hotel, Puerto Rico.

Problems encountered in the newborn and the first and second years of life will be the focus of the program. Scheduled participants include: Michael Jeffrey Maisels, M.D., chief of the division of newborn medicine, associate professor of obstetrics and gynecology, and associate professor of pediatrics for the M. S. Hershey Medical Center; Irving Olshin, M.D., professor of pediatrics at Jefferson Medical College; and William N. Mebane, M.D., clinical professor of family medicine

and clinical associate professor of pediatrics for Jefferson Medical College.

The registration fee is \$50. For

further information write Russell B. Puschak, M.D., Park Professional Building, 2200 Hamilton St., Allentown, PA 18104.

AAP schedules meeting

The American Academy of Pediatrics plans to hold an annual meeting October 16-21 at the Palmer House Hotel in Chicago.

Scientific sessions will be offered under a number of different formats. General sessions, open to all meeting registrants, will look at common practice problems and new developments in pediatric research. Seminars, to be held Saturday, October 16, and Sunday, October 17, will consider

such topics as renal disease in children, management of learning disabilities, sports medicine, and infectious diseases.

Round table discussion groups are planned for Monday, Tuesday, and Wednesday sessions. Representative subjects are developmental delay, child abuse, seizure disorders, visual diagnosis, and the role of the pediatric nurse associate. Special meetings of various sections of the academy are planned to be held throughout the week. Additionally, other organizations, such as the Society for Adolescent Medicine, will hold meetings in conjunction with the session.

For further information contact John P. Lynch, director, Department of Communications, American Academy of Pediatrics, 1801 Hinman Ave., Evanston, IL 60204.

The 1976-77 Pennsylvania Medical Society Roster is now available to Society members. The Roster contains component county society officers, component county society members with addresses and specialty codes, and an al-

phabetical listing of the members and their county affiliations. A complimentary copy may be obtained by contacting Society headquarters, 20 Erford Road, Lemoyne, PA 17043. Additional copies are \$20 each.



MRS. CHARLES K. ZUG, III, left, past president of the Northampton County Medical Society Auxiliary, was recently elected vice chairman of the Democratic State Committee. A State Committeewoman since 1974, she was an alternate delegate to the 1972 National Convention, a delegate to the 1974 Mini Convention, and a delegate and member of the Temporary Platform Committee at the 1976 convention. Mrs. William L. Kanenson, Center, Dauphin County, former State Society Auxiliary publicity chairman, was victorious in the April primary election as the unendorsed candidate of the Democratic Party for the House of Representatives of the 104th District. Mrs. John H. Eves, Bucks County, past president of the State Society Auxiliary, was elected to the Republican State Committee during the April primary.



MDs in the news

Edward T. Auer, M.D., was recently named medical director of the Institute of Pennsylvania Hospital. Dr. Auer has most recently served as chairman and professor of psychiatry in Saint Louis University School of Medicine. Previously he had been on the faculty of the University of Pennsylvania School of Medicine in the departments of medicine and psychiatry for 14 years. Dr. Auer is a fellow of the American College of Psychiatrists and a charter fellow of the American College of Psychoanalysts.



DR. AUER



DR. COPELAND

Adrian D. Copeland, M.D., clinical associate professor of psychiatry at Jefferson Medical College, was recently elected a fellow of the American Psychiatric Association. Dr. Copeland is director of liaison services, coordinator of Jefferson's medicine and society program, and chief of adolescent psychiatry in the college's department of psychiatry and human behavior.

A testimonial dinner was held recently for **Michael Gratch, M.D.**, by friends and former patients in honor of his 30 years of service to the Maytown area. In addition to gifts and testimonials presented by his friends, Dr. Gratch received a citation by the State House of Representatives.

Milton H. Donaldson, M.D., Philadelphia, was recently appointed vice president in charge of cancer control, training, and education at the Fox Chase Cancer Center, associate medical director of the Center's American Oncologic Hospital, and associate director of cancer control at the Institute for Cancer Research.

Since 1970 Dr. Donaldson has served as director of pediatric oncologic training, associate oncologist, and senior physician for the Children's Hospital of Philadelphia, and associate professor of pediatrics for the University of Pennsylvania School of Medicine.

William R. Host, M.D., Tunkhannock, received a 1976 alumni medal for conspicuous alumni service from the Columbia University Alumni Federation during the organization's seventy-eighth annual luncheon, held recently in New York City. Dr. Host is chief of surgery at Tyler Memorial Hospital, Tunkhannock, and Wilkes-Barre General Hospital.

Paul P. Bricknell, M.D., Hershey, was appointed recently as medical advisor to the respiratory therapy department in Holy Spirit Hospital, Camp Hill. He is a diplomate of the American Board of Anesthesiologists, a fellow of the American College of Chest Physicians, and a fellow of the Faculty of Anesthesiologists of the Royal College of Surgeons, England and Ireland.

Sunder H. Mansukhani, M.D., recently became professor of pathology for the Medical College of Pennsylvania. Formerly associate professor of pathology, he is director of medical education in the department of pathology. In 1975 Dr. Mansukhani was appointed as a consultant by the National Cancer Institute and visited the Cairo Cancer Institute, Egypt, as a member of the project site visiting team.

An honorary doctor of science degree from Wilkes College was recently presented to **Sheldon G. Cohen, M.D.**, Pittston, for distinguished work in the field of medical research and teaching. Dr. Cohen, formerly a teaching and research professor at the college, is currently chief of the Allergy and Immunology Branch of the National Institute of Allergy and Infectious Diseases. Since 1972 he has served as a member of the board of directors of the Allergy Foundation of America. From 1963-69 he was historian of the American Academy of Allergy and in 1971 received the academy's distinguished service award.



E. LEE PORTER, M.D., medical director of Fairmount Farm Hospital, presents a plaque honoring the hospital's medical staff and cofounders Drs. Daniel J. McCarthy and George Wilson during Fairmount's fiftieth anniversary observance. Particular recognition was given to staff member Frederic H. Leavitt, M.D., 88, who was the Fairmount Corporation's first secretary.

Victor F. Greco, M.D., of Drums, has been appointed medical consultant to the Bureau of Comprehensive Health Planning of the Pennsylvania Department of Health. Dr. Greco will act in an advisory capacity, reviewing and assisting in the formulation of programs for health planning and delivery. Under review at present are spinal cord injuries and open heart surgery. Dr. Greco is active in health planning, having recently been appointed to the Health and Hospital Planning Council of northeastern Pennsylvania. He serves on the Governor's Advisory Committee on Pennsylvania Coal Workers' Respiratory Disease, and was instrumental in the opening of a clinic for chronic lung disease at Hazleton State General Hospital.



DR. GRECO



DR. McDONALD

The Pennsylvania Academy of Ophthalmology and Otolaryngology recently presented a distinguished service award to **P. Robb McDonald, M.D.**, a Philadelphia ophthalmologist, during the organization's annual convention. Dr. McDonald, consulting surgeon and consultant to the retina service of Wills Eye Hospital, and professor of ophthalmology for Jefferson Medical College, was cited for extensive service in his field.

David M. Shearer, M.D., recently received certification in nuclear medicine. Also certified in internal medicine and endocrinology, Dr. Shearer is coordinator in internal medicine, chief of the division of endocrinology, and director of the endocrine clinic at York Hospital.

Vincent Prioletti, M.D., New Castle, was cited for 50 years in the medical profession during the recent annual

meeting of the Lawrence County Medical Society. **David W. Clare, M.D.**, trustee of the Tenth Councilor District, was guest speaker and presented a certificate and plaque to Dr. Prioletti.

Recently certified by the American Board of Urology was **Jorge Miranda-Maranson, M.D.**, Carbondale. He has been a staff member of St. Joseph's Hospital in Carbondale since 1973.

Recently certified by the American Board of Family Practice were **Joseph A. Lieberman, III, M.D.**, Lower Macungie Township, and **Jonathan E. Beck, M.D.**, Hatboro. Dr. Lieberman is president of the Lehigh Valley Chapter of the American Academy of Family Physicians and an alternate delegate to the State Society House of Delegates.

Takeo Yamashita, M.D., was chosen to receive the first distinguished service award from the residents and attending physicians of Allentown and Sacred Heart Hospitals and the Allentown and Sacred Heart Hospital Center. Dr. Yamashita has practiced in Allentown since 1931.

John M. Eisenberg, M.D., recently addressed the national meeting of the American Federation for Clinical Research, held in Atlantic City, N.J. He discussed "Computer-Based Chart Audit to Detect Overutilization of Laboratory Tests." He is an associate in community medicine at the University of Pennsylvania School of Medicine, where he was appointed Robert Wood Johnson Foundation Clinical Scholar.

William I. Smith, Jr., M.D., assistant professor of pathology at the University Health Center of Pittsburgh, was recently awarded the second annual Judy Finkelstein Memorial Award for research in clinical immunology and rheumatology. His project, "Immunologic Reactivity of Synovial Fluid Lymphocytes," examined the effects of lymphocytes on synovial cells within a mono-layer tissue culture system. Certain results of the study indicate that lymphocytes may protect the joint from the damage of rheumatoid arthritis.

Paul H. Neese, M.D., Bala Cynwyd, recently received the State Society's award in honor of 50 years of service in medicine. Additionally, Dr. Neese recently participated in the 50 year reunion of the class of 1926 of the University of Pennsylvania School of Medicine. Dr. Neese has engaged in the practice of surgery, obstetrics, and general practice over the years. He is currently a general practitioner and a retired staff member of the Graduate Hospital of the University of Pennsylvania, Physicians' and Surgeons' Hospital, and the American Hospital for Diseases of the Stomach.

Michael J. Prendergast, M.D., York, was recently certified by the American Board of Urology. Dr. Prendergast is editor of the *Bulletin* of the York County Medical Society. He has been a member of the staff of York Hospital since 1970.



DR. PRENDERGAST



DR. BURKLE

Joseph S. Burkle, M.D., was recently elected to the American College of Nuclear Medicine. He is director of York Hospital's department of nuclear medicine and assistant clinical professor of medicine for the University of Maryland School of Medicine.

William S. Frankl, M.D., was recently named president of the Southeastern Pennsylvania Chapter of the American Heart Association. Dr. Frankl is professor of medicine and director of the division of cardiology at the Medical College of Pennsylvania.

Daniel W. Hottenstein, M.D., was recently appointed assistant radiologist in the sections of diagnostic radiology and nuclear medicine in Harrisburg Hospital. He was certified by the American Board of Radiology in 1973.

Emily Hartshorne Mudd, M.D., professor emeritus in the department of psychiatry in the University of Pennsylvania School of Medicine, was recently selected as a subject of the Oral History Project of Radcliffe College's Schlesinger Library. The purpose of the project is to document evidence of the vital role played by women in the delivery of health services, maternal and child care, family planning, and voluntary associations. Her major contributions to medicine were her pioneering activities in birth control counseling and marriage counseling. In the 1930s she founded the Marriage Council of Philadelphia, which was incorporated, along with the division of family studies, into the University of Pennsylvania's department of psychiatry, with Dr. Mudd as director. In 1956 she was the first woman to be named to a full professorship in the school of medicine.

Wallace H. Clark, Jr., M.D., was recently chosen as the recipient of the Lucy Wortham James Clinical Research Award of the Society of Surgical Oncology (the James Ewing Society) for his work over the past 20 years dealing with development of a classification system for melanomas. He is professor and chairman of the department of pathology at Temple University School of Medicine. In December 1975 Dr. Clark received the

first scientific award of the Philadelphia Division of the American Cancer Society for his work.

Cora C. Lenox, M.D., associate professor of clinical pediatrics for the University of Pittsburgh School of Medicine and cardiologist for the Children's Hospital of Pittsburgh, received the Commonwealth Board award of the Medical College of Pennsylvania in recognition of her unique contributions to medicine and for her years of practice and research in the field of pediatric cardiology. She received the award during the recent annual luncheon of the board.

David F. Archer, M.D., was recently named associate professor of obstetrics and gynecology at the University Health Center of Pittsburgh. Dr. Archer is a faculty member of the University of Pittsburgh School of Medicine. Prior to joining the faculty in 1970 he was a National Institutes of Health postdoctoral fellow at the Swedish Medical Research Council, Division of Reproductive Endocrinology.

Joseph M. Skutches, M.D., has been named chairman of the professional division of the Greater Bethlehem Area United Fund Drive. He is a past president of the Northampton County Medical Society.

Stephen L. Schwartz, M.D., was appointed recently as associate director for medical affairs for Northwestern Institute of Psychiatry in Fort Washington. He is former acting director of the Hahnemann Community Mental Health/Mental Retardation Center, Philadelphia, former associate professor of psychiatry and director of the emergency psychiatric service of Hahnemann Medical College and Hospital.



DR. SCHWARTZ



DR. ARCE

A. Anthony Arce, M.D., was recently appointed director of the Hahnemann Community Mental Health/Mental Retardation Center. He is professor and deputy chairman of community mental health in the department of mental health sciences at Hahnemann Medical College and Hospital.

Jefferson Medical College's Christian R. and Mary F. Lindback Award for Distinguished Teaching was recently presented to **Carla Elizabeth Goepp, M.D.**, and **Gabriel Ceron, M.D.**, at Jefferson's annual class day exercises. Dr. Goepp is assistant professor of medicine and Dr. Ceron is assistant professor of anatomy at Jefferson.



DR. GOEPP



DR. CERON

James A. Welty, M.D., was recently awarded an emblem from the Venango County Medical Society for 49 years of service to the Venango community and the medical profession. Dr. Welty retired from active practice in December.



R. ROBERT HERRICK, right center, executive vice president of the Health Service Plan of Pennsylvania (HSP), receives a check for \$1 million from William Stanley, of the Department of Health, Education, and Welfare, while H. Newton Spencer, M.D., right, HSP chairman, and Robert E. Snyder, HSP president, look on. HSP is only the second HMO in the state and the twelfth in the nation to meet HEW standards.

Patient welfare and the 'right to know'

The American Society of Internal Medicine at the annual meeting in Atlanta voted to accept patient package inserts, PPIs, when it can be shown through clinical trials that they increase patient compliance and result in improved patient health.

PPIs, predicated upon the "right to know" theory, are drug package inserts similar to the physician package inserts but are shorter and written in lay language. Their advocates hope to achieve better patient education, especially with regard to interactions and adverse reactions, through their use. They are not intended and should not be used to replace the physician as the primary source of drug information for patients.

Arguments both pro and con have been advanced, neither of which are totally without merit. Proponents aver that PPIs involve the patient more in his therapy especially since they describe and alert patients to reactions that ought to be reported. In addition, they describe less serious side effects and warn against potentially dangerous interactions. All these, it is said, will contribute to increased patient compliance. Further, for the non-prescription drugs most often used for self-treatment, the PPI may be the only source of information. No drug that is effective is totally without risk, so that for the over the counter preparations, PPIs have potential benefits.

Opponents argue that patients who are made aware of all the possible adverse effects of their therapy may be frightened into refusal of treatment, thereby decreasing compliance. Indiscriminate dispensing of PPIs with prescriptions might cause greater anxiety in psychiatric patients and thus hamper their therapy or induce non-compliance. For the patient with hypochondriacal tendencies, PPIs will be a veritable gold mine.

Assuming that the PPI will be of value to certain groups of patients but not to others, possible alternatives of usage should be considered rather than mass distribution. For example, if a physician judges that drug information to reinforce or supplement what he has imparted would be beneficial, he could indicate on the prescription that a PPI be included. Another possibility is the structuring of the PPI to include a brief summary and account of interactions of the drug.

Although the PPI may afford the physician additional protection in informed consent cases, it should not be used as the sole source of information on drugs. One of the basic tenets of medicine is, "first, do no harm." Judicious use of the PPI will be required to fulfill this directive.

David A. Smith, M.D.
Medical Editor

Guest editorial

Who's who in plastic surgery?

With federal agencies and hospitals increasingly concerned with definitions, privileges and capabilities, it is incumbent on the medical profession to understand who's who in the rapidly growing field of plastic surgery.

It is well recognized that plastic surgery as a method or discipline is practiced by surgeons certified by the American Board of Plastic Surgery, and designated as plastic surgeons. It is less well recognized that plastic surgery is also practiced by specialists in a particular region or organ system of the body, who during their training have mastered the

specialty region and the methods of plastic surgery peculiar to that region. Some of these specialists have become known as regional plastic surgeons.

Unlike general plastic surgeons, regional plastic surgeons may not present a consistent identity pattern. Ophthalmic plastic surgeons may refer to themselves simply as ophthalmologists, or may add the designation "plastic surgeon" to their specialty title, for example ophthalmic plastic surgeon. Likewise, this may be true of dermatologists, who may use the title, dermatologic plastic surgeon. Some otolaryngologists may practice under the title of "head and neck surgeon" or "facial plastic surgeon." Orthopedists, obstetrician-gynecologists, urologists, neurosurgeons, colorectal surgeons, and general surgeons do not usually add the term

Dr. Marlowe is associate professor of otolaryngology at the Medical College of Pennsylvania, in Philadelphia.

"plastic" to their specialty title, though they may utilize plastic and reconstructive surgical techniques.

It has been estimated that 1,000 ophthalmologists do a significant amount of plastic and reconstructive surgery, and that 4,000 otolaryngologists perform regional plastic and reconstructive surgery. In addition, estimates show 300 dermatologists practicing plastic surgery of the skin and its appendages, and 180 maxillofacial surgeons devoting full time to plastic and reconstructive surgery of the head and neck.

Conservatively, it has been suggested that 22,000 American physicians practice regional plastic surgery, with more than 7,000 of that total performing plastic and reconstructive surgery in the head

and neck area alone. These numbers are all the more significant when one realizes that there are only an estimated 1,500 specialists designated plastic surgeons.

It is obvious that no medical specialty has the exclusive ability to perform plastic and reconstructive surgery, and no board certification or medical title can insure fine surgical results. In counseling our patients with regard to plastic surgery, it is good to remember that the most important consideration is not the surgeon's title, but his ability as borne out by his results.

Frank I. Marlowe, M.D.
Philadelphia



correspondence

To the editor:

I am interested in finding the incidence of allergic reactions to chocolate because of a recent query I received from a chocolate manufacturer.

I would appreciate hearing from physicians the estimated number of their patients allergic to chocolate, and the symptoms produced. I would also appreciate receiving specific case reports, results of laboratory tests, and any other comments on the subject.

Claude A Frazier, M.D.
Asheville, N.C.

To the editor:

I am writing in regards to the recent protest in Harrisburg by the MAUL group against the motorcycle helmet law. I am a general surgeon in practice here and completed my residency at the Polyclinic Hospital. From there I went to Baltimore as a fellow in the Shock Trauma Unit where we served as a statewide referral center for vehicular accidents of all sorts. In the year that I was at the Shock Trauma Unit there were several observations which were quite easily made.

We saw over 1,100 trauma patients in a year, the majority of which (well over 80 percent) were from vehicular accidents. Head injury was present in over 70 percent of the people involved in vehicular accidents. These head injuries were usually in association with other injuries, but the most serious determinant of the trauma victim's prognosis was the

extent of his head injury. The head injury itself was directly responsible or a contributing factor for death in 50 percent of our mortalities. Of the people who actually did survive, the head injury was a major determinant in disability requiring prolonged hospitalization or rehabilitation.

In contrast to the automobile victims who frequently sustain both facial and head trauma, motorcycle victims who were wearing helmets sustained injuries which were of perhaps as great a magnitude but not as life threatening as head injury. We could actually differentiate without any prior information whether a victim had come from a motorcycle accident or from an automobile accident merely on the presence or absence of a head injury. A motorcyclist wearing modern helmet protection is far safer than the unrestrained, unprotected rider.

Further, in regard to the MAUL proposition that automobile occupants should wear helmets, I would like to add that a person properly restrained in an automobile with both lap and shoulder type harness has far less chance of having a head injury than either the unrestrained occupant of an automobile or the helmetless motorcycle rider.

I realize that the motorcycle helmet as constructed today is somewhat a nuisance and somewhat confining; however, that helmet does not offer any decrease in visibility. We must also consider that it is essentially the only safety barrier between a motorcycle rider and an accident. I feel it is not too much of a cross to bear.

J. Stanley Smith, Jr., M.D.
Harrisburg

When **impotence** due to
androgenic deficiency

is driving them apart



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Methyltestosterone N.F. — 5, 10, 25 mg.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosterone-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Vitamin D 250 U.S.P. Units
Thiamine Mononitrate 2.5 mg
Riboflavin 2.5 mg
Ascorbic Acid 25.0 mg
Folic Acid 0.1 mg
Vitamin B-12 1.5 mcg

Methionine 12 mg
Choline Bitartrate 15 mg
Inositol 10 mg
Calcium Pantothenate 2.5 mg
Pyridoxine 0.25 mg
Copper (from Copper Sulfate) 0.25 mg
Zinc (from Zinc Oxide) 0.25 mg
Iodine (from Potassium Iodide) 0.075 mg
Calcium (from Dicalcium Phosphate) 72.5 mg
Phosphorus (from Dicalcium Phosphate) 55 mg
Potassium (from Potassium Sulfate) 2.5 mg
Manganese (from Manganese Sulfate) 0.5 mg
Magnesium (from Magnesium Sulfate) 0.5 mg

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Osteoporosis

ACTION AND USES DOSAGE: 1 tablet after breakfast and supper or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. **PRECAUTIONS:** Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. **CONTRAINDICATIONS:** Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. **AVAILABLE:** Bottles of 100 and 500 tablets.

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Go to hell, Washington—and take Harrisburg with you!

ABRAHAM J. TWERSKI, M.D.

Pittsburgh

This is the first of a series of articles under this intriguing title. They will appear monthly in PENNSYLVANIA MEDICINE and will recount the author's personal experiences to document his statement that the world of government is a 'paper world.'

I suppose I am writing this out of frustration, the frustration arising from my sense of relative helplessness in observing the deterioration of our system of health care, as government continues to make constant inroads in control of our health care delivery system. Each day the approach of this threat becomes more vivid and imminent, and it is clear that much of the country is being taken unawares. Already medicare and medicaid have made significant inroads, and reams of regulations that are already in effect, with reams more on the drawing boards, are threatening to erode one of the world's most effective systems of health care. All this is occurring under the guise of beneficence, and it is the latter that I wish to clarify. If something is to be forced upon us, so be it. But let us not be gullible fools, duped into following the Pied Piper to our own destruction.

It still eludes me why anyone should imagine that the Federal Government can manage a system of health care with any greater degree of efficiency than it managed the Viet Nam war. Indeed, I entertain the possibility that the level of governmental frustration may rise so high that it

may well decide to bomb the hell out of hospitals, but this time with greater success than in the Viet Nam venture.

In order to understand the fundamental weakness which makes governmentally administered medicine a practical impossibility, it is essential that we understand a basic function of governmental-bureaucratic psychology. First it must be under-



Dr. Twerski is medical director of the Gateway Rehabilitation Center and clinical director of the department of psychiatry in St. Francis General Hospital, Pittsburgh. He received his M.D. degree from Marquette University Medical School, interned at Mt. Sinai Hospital, Milwaukee, Wisconsin, and served his residency in psychiatry at Western Psychiatric Institute and Clinic, University of Pittsburgh. He was board certified in psychiatry in 1966.

stood that there exist such things as ideas that are delusions; i.e., they are fixed ideas, false beliefs, that are refractory to change by either logical reasoning or even demonstrable proof to the contrary. Delusions occur, of course, in psychoses, where the mind affected by mental illness adheres to unrealistic ideas that defy refutation, as when a patient believes that he is the Messiah, and that the entire country is in the service of the devil, all plotting to destroy him. Delusions also occur in some cultures and subcultures, where the commonality of a belief precludes its characterization as a delusion. For example, there are those subcultures where the belief in voodoo is well-entrenched, and the latter is accepted as fact. Although some phenomena of voodoo have indeed been demonstrated to the satisfaction of rigorous scientific criteria, there is ample explanation of their means of efficacy without the assumption of supernatural magical forces. Although western civilization looks upon the belief in magic as a delusion, those who maintain this delusion are not classified as psychotics.

I have come to realize that among the subculture of government—in all three divi-

sions: executive, legislative, and judicial, with all their respective bureaucracies—there prevails a fixed idea, an unrealistic belief, a delusion in the full sense of the word. This delusion is that *existence on paper is existence in reality*. If we do not grasp this phenomenon, we will be at a total loss to understand the *modus operandi* of government. Once this fact is appreciated, the whole thing begins to make sense.

How this delusion developed is fertile ground for investigation by governmental anthropologists. (We have physical anthropologists, social anthropologists, cultural anthropologists, so why not governmental anthropologists?) Perhaps it is due to the fact that government deals with so many paper items—bills, regulations, treaties, agreements, opinions, briefs, appeals, etc., and the more complex government becomes, the more paper work is required for its function. Actually, since each paper tends to increase the complexity, there exists a vicious cycle, wherein paper begets paper. **The sum total of this situation is that a conception develops within government that the world is comprised of paper, and that humans are creatures that read paper, interpret paper, tear up paper, carry paper, file paper, etc.**

I am not at all being facetious when I refer to the persistence of this delusion, that paper constitutes reality. How else do you explain the statement of a prominent senator, at a time when we were losing our pants in Viet Nam and looking for some way out of the mess, that we simply pull out and declare the war won and ourselves the victors? Many people thought that this was his idea of a joke, to claim victory in retreat, when the casualties were in the thousands. But I am certain that the senator was in dead earnest, because in Washington, an official document

declaring victory is a victory, and if you have difficulty grasping this type of mentality, remember that, just as the psychotic world of the paranoid is as real to him as your world is to you, and just as the world of spirits and hexes is as real to the believer in magic as yours is to you, so the paper world of government is as real to it as your world of experience is to you. In this light, we might better understand the feeling of smug security felt by the paper shredders. To us, the shredding of incriminating documents may appear as a futile attempt to destroy evidence; to Washington mentality, destroying paper is equivalent to destroying the event. If the papers do not exist, the event does not exist. Now you will say this is a crazy kind of thinking. That is how many of us might feel about voodoo, which is certainly not considered "crazy" in its own subculture. I am not labeling nor diagnosing government mentality, only describing it.

The importance this has for health care consideration will be elaborated on ahead, but the essential point is obvious. In a governmental health care system, if a document says you have recovered from a heart attack, then you *have* recovered; period, end of report. The actual state of your health in your own reality has no significance whatever. Reality is what the piece of paper says, and it is the paper reality, not the flesh-and-blood reality, that will determine the type of care you receive, the benefits which you will receive, the coverage of treatment provided for you, etc., etc. Specific examples of how this is happening right at this very moment under governmentally-controlled health systems will be given later on. **At this point, I only wish to point out and emphasize the existence of these two worlds, of which we in our naivete may be unaware; i.e., the world of our own reality in our daily lives com-**

prised of our own bodies and souls, our families, our homes, our jobs, the sources of our sustenance etc.; and the world of paper reality, as perceived by government to be the true reality.

We hear frequent outcries of the injustice of our judicial system, wherein the rights of innocent victims are totally neglected, but the rights of those implicated in crimes are fully protected. We abhor a system where years may elapse before a person apprehended for a crime is brought to trial, and the endless delay of appeal which may allow him to die of old age before being brought to justice. There are many discussions and debates regarding the philosophy of justice, but all these miss the point completely. The inefficiency of our judicial system does not lie in a faulty philosophy, but rather that it too operates in the paper world, and on paper the system may appear ideally just. Yet the judicial system is that body of government entrusted with protecting our very lives. If government already has this type of system to protect your very life, is it not reasonable to assume that any system that it designs to care for say, your liver, which is only a part of your life, will not be more efficient? To the American people, I say only that if you want your pancreas and lungs to be cared for in the same way that your right to walk down the street alive and safe is being protected, just bring government into health care delivery.

I doubt that anyone will deny that there were and are many shortcomings in health care delivery, and there is no point in defending mistakes. However, before attempting to solve the problem by turning it over to Big Brother, it would be well to note just how efficient and successful are those health programs in which Big Brother already has a share. (Continued in October)

**Fourth Annual
Friends Hospital Clinical Conference
VIOLENCE AND RESPONSIBILITY**

September 23 and 24, 1976

FRIENDS HOSPITAL, PHILADELPHIA

**Presented by Friends Hospital in cooperation with
the Department of Mental Health Sciences of
Hahnemann Medical College and Hospital**

Thursday, September 23

Morning

"A History of the Anglo-American Legal Psychiatry of Violence and Responsibility" - Jacques Quen, M.D.

"Protection from and Prevention of Physical Abuse: The Need for New Legal Procedures" - The Honorable Lois Forer

"The Psychiatrist's Role in Dealing with Violence" - Seymour Halleck, M.D.

Afternoon

Panel Discussion - "Criminal Responsibility: Psychiatric and Legal Issues" Robert Sadoff, M.D. - Chairman (Judge Lois Forer, Seymour Halleck, M.D., Jacques Quen, M.D.)

Evening

Dinner Address - "The Psychosocial Roots of Violence" - Judd Marmor, M.D.

Friday, September 24

Morning

"The Prediction of Dangerousness and the Protection of the Public" - Jonas B. Robitscher, M.D.

"The Violent Individual: Mad or Bad? - Punish or Treat?" - Jonas Rappeport, M.D.

"The Mental Health Procedures Act of 1976 - A New Direction for Pennsylvania" - The Honorable W. Louis Coppersmith

Afternoon

Panel Discussion - "Clinical Management: The Madness/Badness Dilemma" Israel Zwerling, M.D. - Chairman (Senator Coppersmith, Jonas Rappeport, M.D., Jonas B. Robitscher, M.D.)

Advance registration fee of \$85.00 (payable to Friends Hospital) includes lunches at Friends Hospital both days and dinner Thursday evening at the Marriott Motor Hotel. Category I credit.

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Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Patients with glaucoma, prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium® (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacologic effects of agents, particularly potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are avoidable in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE

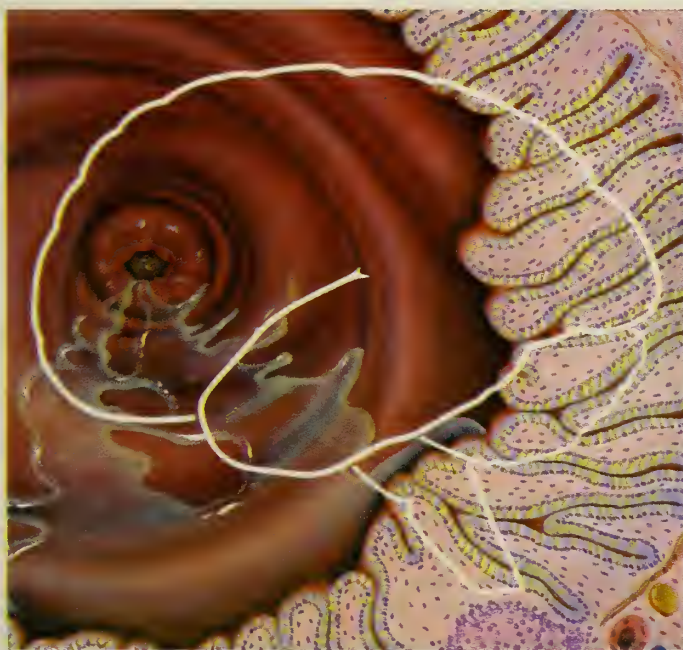
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* This drug has been evaluated as possibly effective for this indication. Please see
preceding page for brief summary of product information.



Common suggestions arising from surveys—part II

LEIF C. BECK, C.P.B.C., LL.B.

VASILIOS J. KALOGREDIS, J.D.

Bala Cynwyd

In our last article we discussed several areas of concern commonly arising from our surveys of medical practices. This article continues in that vein by considering several other ideas repeatedly arising in surveys we have recently performed.

Professional corporation matters

While we believe professional corporations are excellent formats for many (though not all) medical practices, our surveys have uncovered some common areas of both present and potential future trouble. A few are discussed below.

Taking full advantage of the corporate form—Many practices are simply not taking full advantage of the professional corporation form. Since incorporation is costly in terms of advisors' fees and other expenditures, we consider such failures to be very unfortunate.

Some doctors, for example, have refrained from committing themselves to a maximum 25 percent retirement plan contribution out of concern that such an annual obligation could be restrictive on their personal finances in future years. The simple solution to such a concern is for the practice to adopt a pension plan (involving a fixed obligation which must be met every year) of approximately 10 percent of compensation and a profit sharing plan allowing up to 15 percent of salary to be contributed. The advantage of this combination is that since a profit sharing plan is not obligatory (does not *require* any annual contribution level), a practice can decide each year to contribute anywhere from 0 percent to 15 percent of all participants' pay into it.

Many physicians have been unaware that their retirement plans allowed them to make "voluntary contributions." Although they are not tax deductible when made by a doctor from his personal funds, the income generated from them is tax-free (really tax-deferred) until distributed at retirement or other termination of employment with the corporation. The voluntary contribution idea is particularly relevant at this time since under the Pension Reform Act (ERISA) the amount a doctor may contribute will in many cases be less than under old law. Several doctors we have surveyed were surprised to learn that the year ending before December 31, 1976, would provide their last opportunity to contribute up to 10 percent of their aggregate

compensation (all pay) over the years running from the plan's adoption. Since the voluntary contribution has proved to be a worthwhile investment medium for physicians with extra cash to invest, we feel the deadline under ERISA is important.

Too many physicians have failed to take full advantage of the corporate form by not adopting fringe benefits other than retirement plans. A corporate plan should, for example, generally be established to have the corporation reimburse or pay directly the medical expenses (including medical insurance and disability insurance) of each incorporated physician and other key employees. We strongly recommend that at least one non-physician owner-employee be included in the plan to help counteract potential IRS arguments that it is for "shareholders only" and not for "employees," as tax law requires. We also believe that maximum limits should usually be set as to the amount of benefits the plan will provide (either "dollar-wise" or as a percentage of salary) to make the plan "real."

Group term life insurance is another corporate fringe benefit unknown to many physicians. It allows the corporation to pay for an employee's life insurance with dollars which are tax deductible by the corporation and yet not taxed to the employee. It is thus an excellent vehicle for a physician to add to his present life insurance or replace other more expensive life insurance. Even though a group term program requires that all full-time employees must have some insurance provided for them, in almost every instance group term life insurance will be a very reasonable way to obtain life insurance.

We recently encouraged several survey clients to better "sell" their fringe benefit programs to their staff. The Pension Reform Act now requires various notices about fringe benefits, but such information is desirable anyway. Many medical employees are not aware of their benefits, which is unfortunate since a practice should derive whatever employee goodwill such benefits deserve.

Corporate Rescue Jobs—Often we are called in to "rescue" a corporate practice that has not closely followed proper professional corporation protocol. Many of them have "empty minute books," arising from attorneys who incorporated the practice and then were not seen or heard from thereafter. Regular and periodic supervision and review by a practice's advisor are, however, necessary to assure that a professional corporation is well run from a practical and a tax point of view.

Many of the details are admittedly more a matter of

The authors are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd.

"form" than "substance," but the IRS has required them in cases challenging professional corporations. Documentation (minute books, employment agreements, stock restriction agreements, and the like) is most important, which is why we believe ongoing attorney involvement is so valuable to corporate success.

For example, we recently surveyed an office where there was no written stock "buy/sell" agreement. The physicians involved could have encountered a disastrous legal problem if one of them had died under those circumstances. They had verbally agreed to a nominal sum as the fair purchase price of the stock at any doctor's death, with salary continuation reflecting the practice's receivables augmenting that sum. The doctors unfortunately did not fully appreciate that without setting the nominal stock price in writing they were leaving themselves open to a potential lawsuit by an executor of a deceased fellow stockholder arguing that the stock value was much greater. (Mr. Beck recently testified as an expert witness in just such a case, so such lawsuits can and do arise.) From a technical point of view, they could be forced to pay this higher price unless they were protected by a written document saying otherwise. Therefore, such details should not be ignored.

Doctors meetings

A common complaint of physicians in a group is that "we can never make decisions and follow them through." This is often caused by their failure to sit down as a group to discuss on a regularly scheduled basis the practice's purely business matters.

It is imperative that a group (even two doctors) meet on a regular and programmed basis at least once a month—for example, the third Wednesday of every month at lunchtime. Such times should be inviolate, being marked in all the doctors' schedules well beforehand so that nothing else is scheduled during that period.

If the particular practice has an office manager or other "key aide," we normally recommend that she also be involved in such meetings. The "manager" is often the one who will have to implement the authorized actions or at least see that they are implemented, and we believe most arguments for complete confidentiality even from a key aide are mistaken. The meetings also afford the doctors and the manager an opportunity to discuss any office problems in a way that the manager can communicate back to the staff as to matters relevant to them. This approach has worked particularly well in some practices we recently visited where the doctors previously never seemed able to get business matters accomplished. By now involving their respective "senior aides" in the management of the practice, things have been running more smoothly and, most importantly, goals are apparently being attained.

We strongly recommend that all physicians have a monthly financial statement prepared within a few days after the end of each month. Often it is prepared by the "key aide," the preparation and reporting being another reason for having that person's attendance at the doctors' meeting. Such a financial statement should be prepared and in the hands of each doctor a few days ahead of the

monthly meeting. This timing provides each doctor an opportunity to review the statement prior to the meeting, give it some thought and have the opportunity to question and/or comment on any items appearing on the statement. The statement thus affords the doctors an opportunity to evaluate the practice's progress and make decisions based upon the realities of the practice's financial situation. Too many practices lack such statements on a regular and timely basis and therefore are often making decisions in a vacuum, without the information needed to make an informed decision.

Use of advisors

Often related to the question of doctors' meetings and decision-making is the use a practice makes of its advisors—attorneys, accountants, consultants, or whatever.

Doctors often complain that their advisors are not advising but merely performing mechanical tasks (such as preparation of financial statements and document drafting) with nothing else. When this complaint arises, we often find that the advisors have never been asked to supply more than that. In some of those instances, once the practice demanded more time from its advisors, more was achieved. In other cases, the advisors could not supply more and were replaced. Either way, the practices benefited.

The need for advisory involvement is especially relevant in professional corporation situations. As described above, some attorneys who incorporate a practice may not be involved after the initial documentation is complete. In our view, however, during the first year of corporate existence a practice's doctors and advisors should meet from three to six times to assure that things are running their proper course; after that first year there should be at least two meetings a year (at mid-year and during the 12th month of the corporate year for year-end planning) with the practice's advisors.

We strongly recommend that corporate meetings be held with both the attorney and accountant present. In instances in which a doctor meets separately with his accountant and his attorney little or nothing tends to be accomplished since the two advisors may disagree on a matter but lack the opportunity to work out their differences face to face for the doctor's benefit. The doctor can be caught in the middle, having thereafter to telephone each advisor to describe the differences and attempt to come to a decision. It is much better that all advisors meet with the doctor at the same time to allow open discussion and decision for the best interest of the practice.

We also believe such advisors' meetings are important for unincorporated practices. Even an unincorporated practice has various general management, accounting, tax, and other concerns that should be discussed by a doctor or group with its advisors at least a couple of times a year. For example, personnel matters, insurance purchases, fees, collection systems, and the like can and should be discussed with one's advisors who hopefully have experience with other practices that can provide valuable input. The range of client experiences is, of course, the real value of a good advisor. □

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In serious gram-negative infections*

Three good reasons to initiate therapy with Garamycin[®] Injectable

(gentamicin sulfate)



1. Unique spectrum.



**2. Incidence of bacterial
resistance is low and has
not increased significantly.**



**3. Relatively low order of
adverse renal and eighth
nerve reactions when used
as directed.**

*Due to susceptible organisms

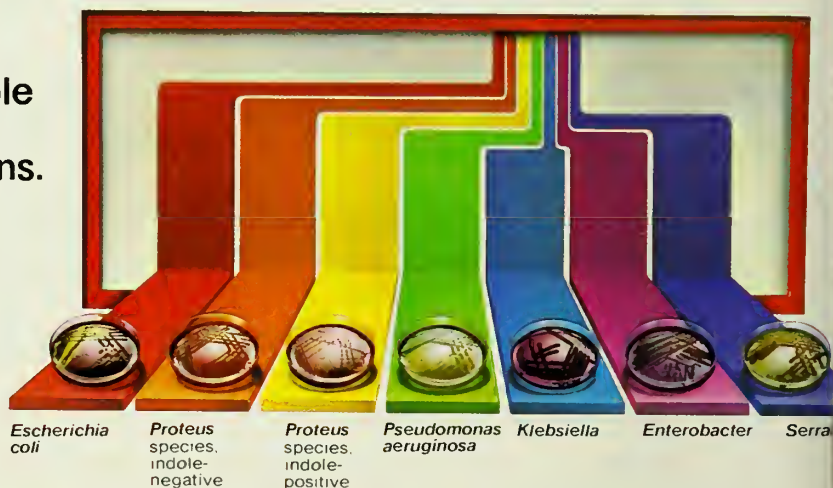
1. Unique spectrum.

Garamycin Injectable (gentamicin sulfate) is active against susceptible strains of seven major gram-negative pathogens.

These are:

Escherichia coli
Proteus, indole-negative
Proteus, indole-positive
Pseudomonas aeruginosa
Klebsiella
Enterobacter } species
Serratia

Garamycin Injectable is also highly effective against susceptible strains of *Staphylococcus aureus* and may be considered when penicillins are contraindicated.



2. Incidence of bacterial resistance is low and has not increased significantly

*In vitro** susceptibility virtually unchanged



* *In vitro* susceptibility data are not necessarily indicative of clinical effectiveness.

In a five-year study¹ in over 180 hospitals, gram-negative pathogens identified and tested demonstrated high susceptibility to GARAMYCIN. From 1971 through 1975 there was virtually no change in the percentage of strains of major gram-negative pathogens susceptible to GARAMYCIN.

In the seven or eight years' experience of one investigator² where gentamicin has been restricted to parenteral use, resistance has not appreciably changed.

Resistance has been demonstrated to develop slowly in stepwise fashion. No one-step mutations to high resistance have been reported.

References

- 1 P.M.R. Bacteriologic Reports—1971-1975.
- 2 Jackson, G.G.: Highlights of a Symposium on Gentamicin, a filmed panel discussion summarizing a symposium on gentamicin, University of California School of Medicine, Los Angeles, January 26, 1971.

3. Relatively low order of adverse renal and eighth nerve reactions when used as directed.

Adverse renal reactions

The risk of adverse renal reactions is low in patients with normal renal function. Usually manifested by nitrogen retention as evidenced by a rising BUN and creatinine, they occur most often in patients with pre-existing renal damage and in patients receiving larger than recommended doses or treated for longer periods of time than recommended. See Warning Box below.



Adverse eighth nerve reactions

The incidence of adverse eighth nerve reactions with GARAMYCIN Injectable is relatively low. When occurring, the effect is predominantly on the vestibular branch of the eighth cranial nerve, resulting in vestibular dysfunction with vertigo and tinnitus. These symptoms have, in many cases, been transitory. The known effect on the auditory branch to date mostly has involved only the high-frequency hearing ranges. See Warning Box below.



A logical choice in serious gram-negative infections[†]

pneumonia
urinary tract infections
septicemia
wound infections

[†]Due to susceptible organisms

Garamycin I.M./I.V.
gentamicin sulfate 80mg/2ml.
injectable 40 mg / ml Each ml contains gentamicin sulfate equivalent to 40 mg of gentamicin

WARNING

Patients treated with GARAMYCIN Injectable should be under close clinical observation because of the potential toxicity associated with the use of this drug.

Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable, usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment.

Monitoring of renal and eighth nerve function is recommended during therapy of patients with known impairment of renal function. This testing is also recommended in patients with normal renal function at onset of therapy who develop evidence of nitrogen retention (increasing BUN, NPN, creatinine or oliguria). Evidence of ototoxicity requires dosage adjustments or discontinuance of the drug.

In event of overdose or toxic reactions, peritoneal dialysis or hemodialysis will aid in removal of gentamicin from the blood.

Serum concentrations should be monitored when feasible and prolonged concentrations above 12 mcg / ml should be avoided.

Concurrent use of other neurotoxic and/or nephrotoxic drugs, particularly streptomycin, neomycin, kanamycin, cephaloridine, viomycin, polymyxin B, and polymyxin E (colistin), should be avoided.

The concurrent use of gentamicin with potent diuretics should be avoided, since certain diuretics by themselves may cause ototoxicity. In addition, when administered intravenously, diuretics may cause a rise in gentamicin serum level and potentiate neurotoxicity.

USAGE IN PREGNANCY Safety for use in pregnancy has not been established.

A logical choice in serious gram-negative infections*

GARAMYCIN® Injectable, brand of gentamicin sulfate, U.S.P. injection, 40 mg. per ml. Each ml. contains gentamicin sulfate, U.S.P. equivalent to 40 mg. gentamicin.
For Parenteral Administration.

WARNING

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USAGE IN PREGNANCY Safety for use in pregnancy has not been established.

INDICATIONS GARAMYCIN Injectable is indicated, with due regard for relative toxicity of antibiotics, in the treatment of serious infections caused by susceptible strains of the following microorganisms:

Pseudomonas aeruginosa, *Proteus* species (indole-positive and indole-negative), *Escherichia coli* and *Klebsiella-Enterobacter-Serratia* species.

Clinical studies have shown GARAMYCIN Injectable to be effective in septicemia and serious infections of the central nervous system (meningitis), urinary tract, respiratory tract, gastrointestinal tract, skin and soft tissue (including burns).

Bacteriologic tests to determine the causative organisms and their susceptibility to gentamicin should be performed.

Bacterial resistance to gentamicin develops slowly in stepwise fashion; there have been no one-step mutations to high resistance.

In suspected or documented gram-negative sepsis, GARAMYCIN may be considered as initial therapy. The decision to continue therapy with this drug should be based on the results of susceptibility tests, the severity of the infection, and the important additional concepts contained in the Warning Box.

For suspected sepsis when the infecting organism is unknown, gentamicin may be administered in conjunction with a penicillin-type drug. Following identification of the organism and its susceptibility, appropriate antibiotic therapy should then be continued. In the neonate with suspected sepsis or staphylococcal pneumonia, a penicillin-type drug is also usually indicated as concomitant therapy with gentamicin.

GARAMYCIN Injectable has been shown to be effective in serious staphylococcal infections. It may be considered in those infections when penicillins or other less potentially toxic drugs are contraindicated and bacterial susceptibility testing and clinical judgment indicate its use.

CONTRAINDICATIONS A history of hypersensitivity to gentamicin is a contraindication to its use.

WARNINGS See Warning Box.

PRECAUTIONS Neuromuscular blockade and respiratory paralysis have been reported in the cat receiving high doses (40 mg./kg.) of gentamicin. The possibility of these phenomena occurring in man should be considered if gentamicin is administered to patients receiving neuromuscular blocking agents, such as succinylcholine and tubocurarine.

Treatment with gentamicin may result in overgrowth of nonsusceptible organisms. If this occurs, appropriate therapy is indicated.

ADVERSE REACTIONS:

Nephrotoxicity: Adverse renal effects, as demonstrated by rising BUN, NPN, serum creatinine and oliguria, have been reported. They occur more frequently in patients with a history of renal impairment treated with larger than recommended dosage.

Neurotoxicity: Adverse effects on both vestibular and auditory branches of the eighth nerve have been reported in patients on high dosage and/or prolonged therapy. Symptoms include dizziness, vertigo, tinnitus, roaring in the ears and hearing loss.

Numbness, skin tingling, muscle twitching, and convulsions have also been reported.

Note: The risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.

Other reported adverse reactions, possibly related to gentamicin, include increased serum transaminase (SGOT, SGPT), increased serum bilirubin, transient hepatomegaly, decreased serum calcium, splenomegaly, anemia, increased and decreased reticulocyte counts, granulocytopenia, agranulocytosis, thrombocytopenia, purpura, fever, rash, itching, urticaria, generalized burning, joint pain, laryngeal edema, nausea, vomiting, headache, increased salivation, lethargy and decreased appetite, weight loss, pulmonary fibrosis, hypotension and hypertension.

DOSAGE AND ADMINISTRATION

GARAMYCIN Injectable may be given intramuscularly or intravenously.

For Intramuscular Administration:

Patients with normal renal function

Adults: The recommended dosage for GARAMYCIN Injectable for patients with serious infections and normal renal function is 3 mg./kg. administered in three equal doses every 8 hours.

For patients weighing over 60 kg. (132 lb.), the dosage is 80 mg. (2 ml.) three times daily. For patients weighing 60 kg. (132 lb.) or less, the usual dosage is 60 mg. (1.5 ml.) three times daily.

In patients with life threatening infections, dosage up to 5 mg./kg. day may be administered in three equal doses. This dosage should be reduced to 3 mg./kg. day as soon as clinically indicated.

In children and infants, the newborn, and patients with impaired renal function, dosage must be determined in accordance with instructions set forth in the Package Insert.

For Intravenous Administration:

The intravenous administration of GARAMYCIN Injectable is recommended in those circumstances when the intramuscular route is not feasible (e.g., patients in shock, with hematologic disorders, severe burns, or with reduced muscle mass).

For intravenous administration in adults, a single dose of GARAMYCIN Injectable may be diluted in 200 ml. of sterile normal saline or in a sterile solution of dextrose 5% in water; in infants and children the volume of diluent should be less. The concentration of gentamicin in solution in both instances normally not exceed 1 mg./ml. (0.1%). The solution should be infused over a period of one to two hours.

The recommended dose for intravenous administration is identical to that recommended for intramuscular use.

GARAMYCIN Injectable should not be physically mixed with other drugs, but should be administered separately in accordance with the recommendation of administration and dosage schedule.

HOW SUPPLIED GARAMYCIN Injectable, 40 mg. per ml., is supplied in 2 ml. (80 mg.) multiple dose vials and in 1.5 ml. (60 mg.) and 2 ml. (80 mg.) disposable syringes for parenteral administration.

Also available, GARAMYCIN Pediatric Injectable, 10 mg. per ml., supplied in 2 ml. (20 mg.) multiple dose vials for parenteral administration.

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For more complete prescribing details, consult Package Insert or Physicians' Desk Reference. Schering literature is also available from your Schering Representative or Professional Services Department, Schering Corporation, Kenilworth, New Jersey 07033.

Garamycin® I.M./I.V.
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INDICATIONS For the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset of action is somewhat slower than that of nitroglycerin.

PRECAUTIONS As with other effective nitrates, some fall in blood pressure may occur with large doses.

Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilatation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

SIDE EFFECTS No serious side effects have been reported. In sublingual therapy a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrates, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustment of the cerebral hemodynamics to the initial marked cerebral vasodilatation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

SUPPLIED 10 mg chewable tablets, bottle of 100. Also 5, 10 and 15 mg scored tablets in bottles of 100. 10 mg scored tablets also supplied in bottle of 1,000.

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Russeck HI AM J M Sc 239:478, 1960



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Rapid-acting chewable tablets (10mg) preferred by many patients. Should be given before anticipated periods of stress to produce an action within 5 minutes and lasting up to 2 hours. Sublingual tablets also available.



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Hyperuricemia, diabetes mellitus, and diabetic ketoacidosis

LARRY H. GOLDBERG, M.D.
Philadelphia

The association of hyperuricemia and diabetes mellitus has been noted in medical literature for nearly two hundred years. Despite the longevity of this postulated association, the existence of such a relationship has yet to be established. Transient hyperuricemia during episodes of diabetic ketoacidosis has been well documented in the literature. However, the reports regarding the prevalence of hyperuricemia in apparently controlled diabetics are conflicting. In view of this uncertain relationship, the recent literature has been reviewed to explore the epidemiological data for and against such an association and the pathophysiological mechanisms proposed for the concurrence of carbohydrate intolerance and hyperuricemia.

In investigating the possible relationship between hyperuricemia and/or gout and diabetes mellitus, the similarities between these two disease states must be considered. For example, there is a high incidence of both disease processes in middle aged patients; the prevalence of ASHD and obesity is higher in both disease states; and, in general, the younger the patient, the worse the expression of either disease. Therefore, there exists the possibility of chance occurrence of these two rather chronic diseases in one individual.

Two large population surveys, Tecumseh and Framingham, studied the prevalence of gout in diabetic patients.¹⁻² Beckett and Lewis found a 1 percent incidence of gout in 800 diabetic patients and stated that the association between these two disease processes is rare.³ Their study demonstrated an additional interesting finding—there was an increased

prevalence of positive family histories for gout in patients with diabetes mellitus when compared to controls.

In contrast, the prevalence of diabetes mellitus in gouty patients has been reported to be higher (these reports vary from 3 percent to 65 percent). A report from the Lahey Clinic stated that most of their patients with both diabetes and gout developed the diabetes subsequent to the development of gout, exhibited positive histories for diabetes in 46 percent, and rarely needed insulin for control of their diabetes.² These findings have been confirmed by others. It was also noted that in those patients with gout and insulin dependent diabetes, the diabetes preceded the gout in 50 percent of the cases.



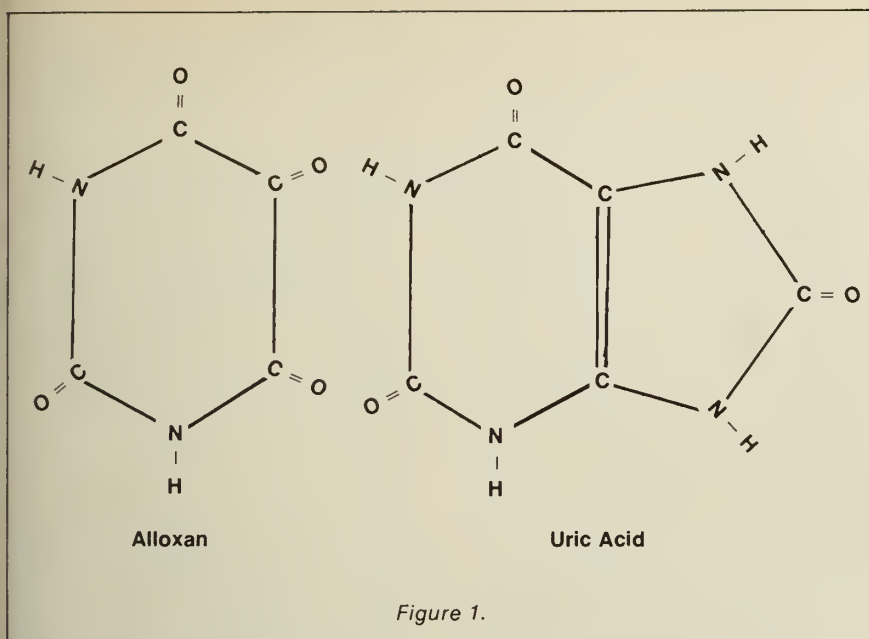
Dr. Goldberg graduated from Case Western Reserve University magna cum laude, Phi Beta Kappa, in 1973 and received his medical degree with the 1976 graduating class of Hahnemann Medical College and Hospital, Philadelphia.

Berkowitz investigated the relationship among gout, hyperlipidemia, and diabetes mellitus and found serum triglycerides greater than 150 mg/100 ml in 75 percent of his 25 patients with gout.⁴ Of these hypertriglyceridemic gouty patients, 68 percent manifested abnormal carbohydrate tolerance as evidenced by elevated fasting blood sugars or impaired glucose tolerance tests. He concluded that there exists a high correlation among gout, serum triglycerides, and carbohydrate metabolism.

Griffith reported the production of diabetes in ten of twelve rabbits injected intraperitoneally with uric acid after the animals had been made glutathione deficient.⁵ Uric acid resembles the diabetogenic substance, alloxan, in chemical structure (Figure 1) and the pancreatic lesions produced by uric acid were similar to those of alloxan induced diabetes mellitus. Similar studies relating uric acid and other chemical analogues of alloxan to production of hyperuricemia in animals suggests that uric acid may be diabetogenic.

Boyle studied the serum insulin response in gouty patients and found a slightly delayed fall-off in plasma insulin response after glucose loading similar to that found in obese patients when compared to normal patients and suggested obesity as a common underlying factor responsible for these abnormalities in plasma insulin responses.⁶

Newcombe also studied the serum insulin responses in a small group of patients with gout.² Relative and absolute insulin deficiencies, blunted initial insulin responses, and delayed peaks of plasma insulin concentration, all of which are consistent with



adult onset diabetes mellitus, were found after glucose challenges. Since some of his patients were thin, he stated that not all diabetes detected in gouty patients can be related to obesity, and that insulin deficiency rather than obesity or insulin resistance represents the cause for carbohydrate intolerance.

A study carried out by Frank revealed that the incidence of overt or subclinical diabetes did not differ significantly among patients with gout and controls.¹³ The study concluded that diabetes has no direct relationship to gout and that obesity should be regarded as the cause of glucose intolerance associated with gout.

Other investigators have shown significantly decreased mean serum uric acid concentrations in diabetic patients when compared to controls. Bartels noted that 50 percent of his

gouty patients with concomitant diabetes mellitus experienced significant improvement of their gout with the onset of the diabetes and postulated a relationship between glucosuria, uricosuria, and clinical improvement of gout.⁷

A long term epidemiological study by Herman and others demonstrated that the level of the lower uric acid values in diabetes was related to the duration of the diabetes.⁸ The serum uric acid level was found to be lower in previously diagnosed diabetics than in newly diagnosed diabetics, and lower in newly diagnosed diabetics than in non-diabetics.

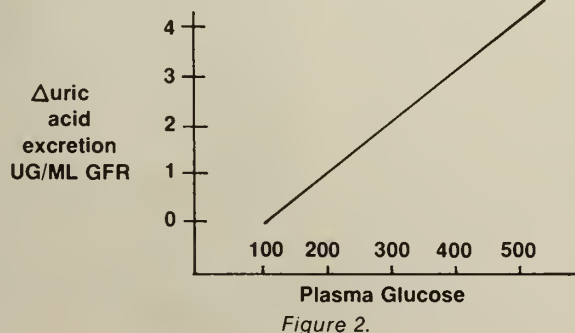
Some investigators have hypothesized that renal tubular basement membrane thickening leading to decreased tubular reabsorption of uric acid is the cause for decreased serum uric acid concentrations in diabetic patients. Contrary to the aforemen-

tioned mechanism, Herman and Kegman state that renal tubular damage is not necessary to explain the increase in uric acid clearance seen in diabetics, since this increase occurs with increased blood sugars and reverts to normal with return to normal blood sugar level.¹⁴

Their proposed mechanism is as follows. Normally both uric acid and glucose are filtered by the glomeruli and reabsorbed in the proximal tubules and tubular secretion is believed to be involved in uric acid excretion. Hypertriglyceridemia leads to an increased amount of glucose filtered by the glomeruli and reabsorbed by the tubules. If it is presumed that this increased glucose reabsorption takes place at the expense of uric acid reabsorption, increased uric acid excretion results. Thus, the hyperglycemia of diabetes mellitus leads to increased excretion of uric acid and subsequently to a decreased uric acid pool and decreased serum uric acid level.

Boner and Riselback have experimentally shown that uric acid excretion is directly related to plasma glucose level (Figure 2) and have suggested that uric acid, in addition to being partially absorbed and then secreted, may also be reabsorbed at a second site distal to its secretory site. The presence of glucose distal to the tubular site of its reabsorption inhibits uric acid reabsorption at uric acid's second, more distal reabsorptive site (Figure 3).⁹ They add that glucose must have a direct effect on reabsorption of uric acid since it has been shown that the osmotic diuresis following mannitol diuresis is only minimally uricosuric.

The pathogenesis of hyperuricemia in diabetic ketoacidosis is better understood. Diabetic ketoacidosis is associated with a higher incidence and a more marked degree of hyperuricemia than known coincidence in non-ketotic diabetes states. Padova and Bendersky demonstrated that the decrease in serum uric acid after the hyperuricemia of diabetic ketoacidosis must closely follow resolution of the hyperketonemia and proposed four possible mechanisms for the hyperuricemia of diabetic ketoacidosis: (1) renal failure and dehydration; (2) coincidence of other



conditions associated with hyperuricemia; (3) drugs and other agents; and (4) protein nucleoprotein breakdown.¹⁰

Renal failure is a common cause of hyperuricemia, but in diabetic ketoacidosis the hyperuricemia probably occurs in the absence of major disturbances in renal function since the hyperuricemia disappears with treatment of the acidosis. However, a decreased glomerular filtration rate secondary to dehydration could be a cause of the hyperuricemia. Numerous conditions, among which are myxedema, eclampsia, hypertension, pernicious anemia, starvation, rheumatoid arthritis, myeloproliferative disorders, and most notably obesity (common to both diseases discussed here) have been documented to accompany hyperuricemia and may represent possible causes for the hyperuricemia of diabetic ketoacidosis. Drugs such as diuretics, ASA, and antihypertensives could theoretically be causative agents for hyperuricemia in ketoacidosis, and lactate is known to exert a minor influence in raising serum uric acid concentrations. Furthermore, glucose *per se* may alter the value of the serum uric acid determination.

In diabetic ketoacidosis, the glycogen depletion leading to gluconeogenesis may represent the most likely explanation for the hyperuricemia. In severe untreated diabetes mellitus, fasting plasma amino

acids occur in association with protein catabolic states and negative nitrogen balance. The purines resulting from nucleoprotein breakdown for gluconeogenesis may account for the hyperuricemia via some unknown mechanism. The progressive return of the serum uric acid to the normal range after correction of the acidosis is in accord with correction of the state of glycogen depletion and the anabolic protein functions of insulin. Padova and Bendersky suggest a relationship between ketogenesis and uricogenesis mediated either directly by insulin deficiency via competitive need for some unknown substrate or indirectly by gluconeogenesis from protein.

Seegmiller found a correlation between increased acetoacetone and β -hydroxybutyrate concentrations and decreased uric acid insulin ratios, and postulated that β -hydroxybutyrate and perhaps acetoacetone interfere with renal elimination of uric acid and constitutes a possible mechanism for the hyperuricemia of diabetic ketoacidosis.¹¹ Idiopathic lactic acidosis, which is frequently associated with diabetes mellitus, is characterized by severe metabolic acidosis with increased lactate concentrations in the blood. Lactic acid mediated alterations in uric acid excretion by the kidney with resultant increased uric acid concentration has been suggested as another possible mechanism for the hyperuricemia of diabe-

tic ketoacidosis.

In conclusion, the correlation between non-ketoacidotic diabetic states and hyperuricemia is indeed an unclear one. There exists epidemiological data which refute and support an association. There is considerable evidence for the existence of frequent positive family histories for diabetes mellitus in patients with gout and for gout in patients with diabetes. There is evidence for decreased serum uric acid concentrations in non-ketoacidotic states possibly mediated through the inhibition by glucose of uric acid reabsorption in the proximal tubule of the kidney, so when gout and diabetes mellitus are concurrent the association is probably due to obesity. The association in diabetic ketoacidosis is much more clearcut—depletion of hepatic glycogen stores and resulting gluconeogenesis with formation of purine metabolites, or inhibition of renal tubular secretion of uric acid by ketone bodies could explain the hyperuricemia. □

REFERENCES

1. Mikkelsen, W. M. A possible association between hyperuricemia and diabetes mellitus. *Arth. and Rheum.*, 8:853, 1965.
2. Newcombe, D.S. Endocrinopathies and uric acid metabolism. *Sem. Arth. and Rheum.*, 2:281, 1972-1973.
3. Beckett, A. G.; and Lewis, A. G. Gout and the serum uric acid in diabetes mellitus. *Quarterly J. Med.*, 29:443, 1960.
4. Berkowitz, D. Gout, hyperlipidemia, and diabetes interrelationships. *JAMA*, 197:77, 1966.
5. Griffiths, M. Uric acid diabetes mellitus. *J. JAMA. Bio. Chem.* 172:853, 1948.
6. Boyle, J. A.; et al. Diabetes mellitus and gout: blood sugar and plasma insulin responses to oral glucose in normal, over weight and gouty patients. *Ann. Rheumatic Dis.*, 28:374, 1969.
7. Bartels, E. C.; Balodimos, M. D.; and Corn, L. R. The association of gout and diabetes mellitus. *Med. Clin. N. America* 44:433, 1960.
8. Herman, J. B.; Medalie, N. H.; and Goldhour, V. Diabetes mellitus and uric acid: a relationship investigated by the epidemiological method. *Adv. Exp. Med. Bio.*, 41B:483, 1974.
9. Boner, G.; and Rieselback, R. E. The effect of glucose upon reabsorptive transport of urate by the kidney. *Adv. Exp. Med. Bio.*, 41B:781, 1974.
10. Padova, J.; and Bendersky, G. Hyperuricemia and diabetic ketoacidosis. *N. Eng. J. Med.*, 267:530, 1962.
11. Seegmiller, J. E.; Goldfinger, S.; and Klinenberg, J. R. Renal retention of uric acid induced by infusion of beta-hydroxybutyrate and acetoacetate. *N. Eng. J. Med.*, 272:351, 1965.
12. Pastegate, A.; and Thior, S. Physiologic approach to hyperuricemia. *N. Eng. J. Med.*, 286:470, 1972.
13. Frank, O. Observations concerning the incidence of disturbance of lipid and carbohydrate metabolism in gout. *Adv. Exp. Med. Bio.*, 41B:495, 1974.
14. Herman, J.; and Kegman, A. Hyperglycemia and uric acid. *Israeli J. Med. Sci.*, 5:1048, 1969.
15. Guyton, A. C. *Textbook of Medical Physiology*. Philadelphia, Saunders, 1971.
16. Pitts, R. F. *Physiology of the Kidney and Body Fluids*. Chicago, Yearbook, 1968.

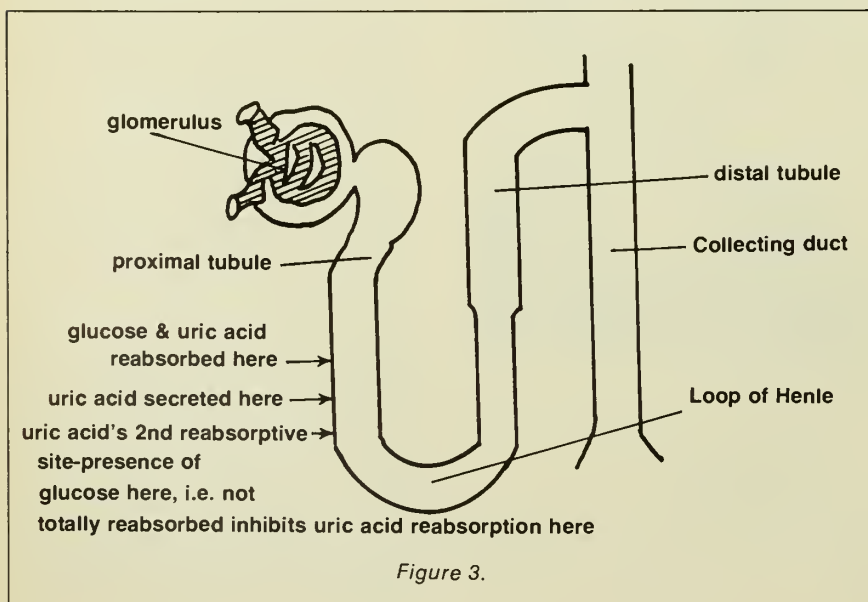


Figure 3.



The edematous hand

WILLIAM P. GRAHAM, III, M.D.

STEPHEN H. MILLER, M.D.

Hershey

Unrelieved edema results in fibrosis, destroying function of the hand. Contusion, fracture, infection, burns, and misguided therapy all can produce sufficient edema to wreak havoc within the hand. Often little appreciation is given to the edema associated with those injuries. Only when the anatomical restrictions of the fascial sleeves and restraining cutaneous envelope of this semirigid cylinder are considered does one realize the potentially devastating effect of increasing and unrelieved edema upon it. Once the pressure within a fascial compartment exceeds the pressure of the venous and lymphatic outflow, Volkmann's contraction is incipient. Ordinarily innocuous constricting items such as clothing, jewelry, or an improperly wrapped dressing may yield irreversible damage by reducing the venous outflow from the injured area.

The relief of edema in the upper extremity must be actively provided without compounding the injury. At times, surgical decompression need only be through the skin sleeve, but

on other occasions, the decompressing incision must extend through the muscle fascia and restraining ligaments (flexor retinaculum).

Thermal injury is potentially one of the most severe insults to the hand. The dorsal subcutaneous and subaponeurotic spaces distend, overburdened with protein exudate. The skin, which can only yield so much, "check reins" the metacarpophalangeal joints into hyperextension, secondarily permitting hyperflexion of the interphalangeal joints. This unnatural attitude facilitates joint contractures by collagen deposition, locking the hand into a fixed deformity. At considerable risk deep within the hand are the intrinsic muscles that become distended and compressed within their restraining fascial compartments resulting in intrinsic plus deformity. Congestion → impaired venous and lymphatic outflow → more congestion → diminution in arterial inflow → ischemia → contracture. Yet the accumulation of edema alone, particularly when it becomes fixed, also promotes cicatrix.

Often the injured hand must be rested; however, in the face of overwhelming congestion (e.g. in a burn) early motion may be essential. Unrestrained elevation is essential but the "hanging" of the hand by a noose to an i.v. pole is a source of discomfort to the patient and exposes the hand to further choking at the wrist by the distal migration of the dressing or cast. Only when the entire extremity is supported (hand, forearm, and upper arm) as in a long arm cast should suspension to an external support be

TABLE I

Treatment of the Swollen Hand

Elevation
Relief of Constrictions
Cast or dressing
Skin or fascia
Immobilization*
Position of function
Early periodic movement of all mobile joints
Early active and active assisted motion
Avoid:
Dependency
Abnormal posturing
Constricting elements

*May not be needed if active motion will help overcome edema and not retard healing.

permitted. The routine use of slings also risks congestion by blocking venous and lymphatic drainage at the elbow. The patient is better served by instructing him to elevate the part and to move each free distal and proximal joint through its complete range of motion multiple times daily. The hand should be raised overhead hourly for a few minutes when the patient is awake. At no time should dependency of the hand be permitted. Splinting and casting should not be excessively prolonged. The hand should be placed in a position which approximates the position of function. Stiffness will follow swelling. Early stiffness that is not rapidly overcome by proper positioning or active motion can become a fixed contracture with considerable loss of function. □

This paper was prepared by the department of surgery, division of plastic and reconstructive surgery, The Milton S. Hershey Medical Center, The Pennsylvania State University, Hershey. The Pennsylvania Division of the American Trauma Society and the State Society's Commission on Emergency Medical Services Assist in the dissemination of information on trauma.

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Dr. Masland addresses House of Delegates

Society President David S. Masland, M.D., keynoted the July 11 Special Session of the House of Delegates, during which the formation of a captive professional liability insurance company was unanimously approved. Following are Dr. Masland's remarks to the House.

While I doubt that we shall bring forth anything as dramatic as the Declaration of Independence, it is a fact that twice, in as many summers, this House of Delegates has gathered in special session to wrestle with a problem so critical to the medical profession that it may be appropriate to compare our deliberations with those of Dickinson, Franklin, Wilson, et al, two hundred years ago.

As you may recall, the proposal to investigate the feasibility of a Society formed and administered insurance company came out of our special session here last summer. Acting on that directive the Commission on Professional Liability Insurance began working. Last fall, the commission's plans were approved by the House of Delegates in Lancaster and the mandate was given to complete the details of the organization, structure, and operation of a Society captive insurance company.

Out of that mandate came a report and recommendation to the Board of Trustees that a stock insurance company be formed. The Board conditionally approved that recommendation and has brought the package here to you this morning for your final decision.

I hasten to add that although in a few minutes I will go over a list of reasons why we should start the captive company, conspicuous by its absence from the list will be any hint that the captive is a solution to the malpractice crisis—for it is not. Make no mistake about it, the captive is only one small piece of the total picture. It will play an important role in moving us closer to the ultimate solution, but will not stand alone as the answer. Most of the problem lies in the system, and until reforms are made to the tort law, the crisis will continue.

By the same token, meaningful tort reform is obstructed by an uncooperative self-serving insurance industry.

Recently we have met privately with leaders of the Pennsylvania General Assembly and subsequently with the leadership of the Pennsylvania Bar Association. In both instances I have pointed out that the present system of settling disputes is too expensive and have attempted to open a serious discussion about reform of the system. I have cited four present conditions which illustrate the need for reform of the tort laws.

1. Health care providers (doctors and hospitals) already put enough money into the system to more than adequately compensate patients.

2. Medicine in Pennsylvania, through peer review activities and the beefing up of the state board, has addressed as seriously as possible the question of bad physicians.

3. A growing body of statistics (from the National Association of Insurance Commissioners) shows that the primary cause of suits is the number of high risk procedures done, not the level of competence of physicians.

4. The insurance industry, though it contributes to the problem, is not the root cause of the crisis.

5. These four conditions lead to the fifth point: namely that the tort system is too expensive and needs reform. But each time we try to discuss tort reform with legislators and the bar, they put the blame on insurance companies.

Certainly the inflexibility and secrecy of insurance companies have provided this convenient straw man. By the same token, rate filings so obscure as to mystify professional actuaries, only reinforce the suspicion that insurance companies are covering up a rip-off. Until the industry provides clear understandable filings with meaningful figures on claims, reserves, profits, and losses, it will continue to be a ready made scapegoat for those who do not wish to face up to the real problem.

One by-product of our own company would be the generation of and access to complete claims and financial data. This would be extremely helpful in our drive for additional legislative reform.

Another value of the captive would be to reduce the malpractice war from two fronts to one. This year it has become obvious to me that we have spent an inordinate amount of physician, staff, and legal time and money fighting the insurance industry. These running battles go all the way back to the spring of 1975 when Argonaut first signaled its intention to leave Pennsylvania.

- There was the suit itself and the subsequent litigation of the suit.

- There were the insurance department hearings in Philadelphia which required weeks of preparation.

- There were numerous rounds of lobbying negotiations with the industry during the spring and summer of '75 regarding amendments to H.B. 1367. Frequently we had more difficulty negotiating the demands of the insurance industry than those of the legislators.

- There were meetings with officials of Medical Protective.
- There were the insurance department hearings this spring.
- And finally there have been the increasing number of harassments by Argonaut as part of their drive to leave Pennsylvania. For example: the attempt to cancel 91 physicians; the threat to revoke binding authority from Frank B. Hall; and most recently the demand for payment in ten days and the attempt to intimidate physicians into retroactively paying a possible rate increase.

Just reviewing these events rekindles my anger. Think of the time spent arguing with the insurance industry, which could have better been spent lobbying for corrective legislation. And despite all this arguing and negotiating, we still arrived on capitol hill lacking the necessary statistics to persuade legislators of needed reforms.

Let us get on with the captive company and hopefully as a byproduct begin to generate some hard facts which legislators will accept. Certainly we can reduce the amount of time and money required to fight unproductive insurance industry wars and zero in on the real target, the Legislature.

The captive also holds out the hope at long last for some innovation in the insurance industry, something which heretofore companies have spurned. We have suggested to the industry that some of the very basic assumptions under which it operates be reexamined; among these are the rating classifications and the two territory concept. Their response has been a deafening silence. We have suggested that specialists should be rated according to the procedures they are actually doing. For example, the OB/GYN physician who limits himself to office gynecology should not be charged the same rate as one who is doing deliveries and surgery. We have questioned the need for corporate malpractice insurance, at least at the current rates. Argonaut's reply has been that they have only one desire—to leave the state. Medical Protective has been similarly negative. They are not interested in any new proposals. The industry has not only failed to respond to our ideas; it has failed to offer any counterproposals of its own. I must therefore sadly conclude that the insurance industry, as it is now constituted in Pennsylvania, has no interest in solving the malpractice insurance crisis, only in financing it.

Make no mistake, I do not see the captive insurance company as "the solution" to the malpractice crisis. And I would avoid a captive if I thought we could do so safely; unfortunately, we would jeopardize the best interests of perhaps half of our membership. The market survey showed a virtual total lack of confidence on the part of PMS members in the joint underwriting association. Not surprisingly, Pennsylvania physicians are highly suspicious of a state government regulated and sanctioned monopoly. Prudence therefore demands that we provide an alternative to the JUA. Here are some of the benefits which may reasonably be expected to come from the captive:

1. At long last instead of fighting our insurance carrier, we can fight shoulder to shoulder with our company to solve the problems. What dollar value can we assign to cooperation, yet how costly is any endeavor without it?

2. We will have access to claims data sufficient to construct an accurate picture of the causes of malpractice in Pennsylvania.

3. We will have complete and accurate cost figures.

4. We will have the ability to innovate where prudent and feasible.

5. We will have the ability to charge rates based on a physician's actual practice rather than by specialty classification.

6. We will have the authority to institute an effective loss control program.

7. We will have the opportunity to launch a medical defense unit and to fight all meritorious cases rather than submit to legalized extortion.

8. Finally, and perhaps more importantly, we will have the freedom to decide our own fate rather than submit to the dictates of a state dominated JUA.

Let us be clear on one point, however. A vote for the captive is not necessarily a vote for lower premiums. It is, however, a vote for control, control of our own destiny.

As I conclude these remarks, let me move from the specific question before us this morning, to the broader issue of the malpractice insurance crisis statewide and nationwide. In 1960 U. S. physicians and hospitals paid \$61 million for malpractice insurance. The 1975 figure was approximately \$1 billion.

The Blue Ribbon panel appointed by Governor Carey of New York to study medical malpractice predicted that premiums for hospitals and doctors in New York State alone will increase to a half billion dollars in the next three to four years. As mind boggling as these figures are, we know that they represent only a fraction of the total cost, for they do not include the cost of defensive medicine, already estimated to be in the billions, nationwide.

All this is catalyzed by exorbitant settlements awarded by emotional juries fanned by self-serving lawyers aided and abetted by the testimony of unethical medical experts, instigated by greedy and spiteful claimants, obsessed with the myth that medicine is an exact science. All of this is fabricated on the mistakes and negligence or genuine malpractice of a small number of physicians.

In the last two years more than 30 states have enacted some form of legislation to cope with the problem. There have been strikes and slowdowns, numerous studies, arbitration panels in one form or another, patient contracts, even serious consideration of trip insurance; all these and many more approaches are being looked at as possible solutions. Despite all this activity, in none of the fifty states has a real solution been instituted.

The solution must be found—it will be found, but I believe it will be a mosaic fitted together piece by piece. I believe that a captive insurance company is an essential part of the framework into which we may fit some of the pieces. While we are putting these pieces together over the next few years, I ask you—I beg of you, one and all—let us work together. Some of us, by virtue of the procedures included in our specialty, feel the effects of the crisis more acutely. This means that those of us who have not yet experienced the crisis as dramatically, must give heavily of our commitment and, yes, of our money to alleviate the problem as quickly as possible.

Dr. Jonathan Rhoads president of philosophical society

Jonathan E. Rhoads, M.D., 1975 recipient of the Society's Distinguished Service Award, was elected president of the American Philosophical Society during the organization's recent bicentennial meeting in Philadelphia. He is the first Philadelphian to hold the office since Owen J. Roberts, Associate Justice of the Supreme Court and dean of the University of Pennsylvania Law School, held it 1952-55.

The American Philosophical Society was established by Benjamin Franklin in 1743. It was developed as an American counterpart of the Royal Society in England and to encourage "... useful knowledge among the British plantations in America," according to its eighteenth century charter. The term philosophy in the eighteenth century encompassed scientific and technological knowledge as well as the abstract intellectual pursuits.

The society, as an organization of the colonies' most substantial citizens, played an intimate role in the founding of the United States. Its headquarters, Philosophical Hall, is on Independence Square and after Independence Hall is the oldest building on the square. In addition to Franklin, its first president, the membership included Thomas Jefferson, president 1797-1814, Thomas Paine, George Washington, and Alexander Hamilton.

Other Philadelphians to hold the presidency were: David Rittenhouse, vice provost, professor of astronomy, and trustee of the University of Pennsylvania; Caspar Wistar, professor in the university's medical school; Edgar F. Smith, provost of the university and president of the Wistar Institute; Thomas S. Gates, university president 1930-44; and Owen J. Roberts.

Dr. Rhoads has been a member of the university's surgical faculty since 1934 and occupied the John



DR. RHOADS

Rhea Barton Professorship as chairman of the department and director of the Harrison Department of Surgical Research 1959-72. He was provost of the university 1956-59.

Having served as chairman of the board of regents and president of the American College of

Dr. Richard Wilbur heads new medical federation

Richard S. Wilbur, M.D., has been appointed executive vice president of the Council of Medical Specialty Societies.

Dr. Wilbur is currently senior vice president of Baxter Laboratories, Deerfield, Illinois. He previously served as deputy executive vice president of the American Medical Association from September 1969 to July 1971, and as Assistant Secretary of Defense, Health, and Environment from July 1971 to September 1973.

Dr. Wilbur graduated from Stanford Medical School in 1946. He is certified by the American Board of Internal Medicine and is also certified in gastroenterology.

Surgeons and president of the American Surgical Association, Dr. Rhoads is active in numerous professional organizations. He now serves as chairman of the National Cancer Advisory Board and editor of the journal, *CANCER*.

Dr. Lucey commissioner of health planning

Denis J. Lucey, III, M.D., was appointed recently as commissioner of the Department of Health's Office of Planning and Development.

Among the responsibilities of the newly created position are: developing comprehensive health planning and health care delivery systems; guiding bureau directors in total development of statewide public health services; establishing policies, standards, and goals governing planning programs; advising the secretary of health on program planning; and recommending and assisting in the preparation of legislation relating to the development and delivery of health services.

Dr. Lucey is a former faculty member of the University of Pennsylvania School of Medicine. He has served as liaison with the Robert Wood Johnson Clinical Scholars Program and as secretary of the executive committee of the department of community medicine. He has served as chairman of the Department of Health's Committee on Health Care Services Task Force on Health Care Costs and Financing of the Advisory Council for Comprehensive Planning.

Dr. Lucey received a bachelor of arts degree from Villanova University, a master's degree in city planning from the University of Pennsylvania, and a medical degree from Temple University School of Medicine.

AMA issues advertising policy statement

The American Medical Association Judicial Council recently clarified the policy regarding physicians' advertising and soliciting patients. Following is the council's statement which appeared in the May 24, 1976, issue of the *Journal of the American Medical Association*:

This statement reaffirms the long-standing policy of the Judicial Council on advertising and solicitation by physicians. The *Principles of Medical Ethics* are intended to discourage abusive practices that exploit patients and the public and interfere with freedom in making an informed choice of physicians and free competition among physicians.

Advertising—The *Principles* do not proscribe advertising; they proscribe the solicitation of patients. Advertising means the action of making information or intention known to the public. The public is entitled to know the names of physicians, the type of their practices, the location of their offices, their office hours, and other useful information that will enable people to make a more informed choice of physician.

The physician may furnish this information through the accepted local media of advertising or communication, which are open to all physicians on like conditions. Office signs, professional cards, dignified announcements, telephone directory listings, and reputable directories are examples of acceptable media for making information available to the public.

A physician may give biographical and other relevant data for listing in a reputable directory. A directory is not reputable if its

contents are false, misleading, or deceptive or if it is promoted through fraud or misrepresentation. If the physician, at his option, chooses to supply fee information, the published data may include his charge for a standard office visit or his fee or range of fees for specific types of services, provided disclosure is made of the variable and other pertinent factors affecting the amount of the fee specified. The published data may include other relevant facts about the physician, but false, misleading, or deceptive statements or claims should be avoided.

Local, state, or specialty medical associations, as autonomous organizations, may have ethical restrictions on advertising, solicitation of patients, or other professional conduct of physicians that exceed the *Principles of Medical Ethics*. Furthermore, specific legal restrictions on advertising or solicitation of patients exist in the medical licensure laws of at least 34 states. Other states provide regulation through statutory authority to impose penalties for unprofessional conduct.

Solicitation—The term "solicitation" in the *Principles* means the attempt to obtain patients by persuasion or influence, using statements or claims that (1) contain testimonials, (2) are intended or likely to create inflated or unjustified expectations of favorable results, (3) are self-laudatory and imply that the physician has skills superior to other physicians engaged in his field or specialty of practice, or (4) contain incorrect or incomplete facts, or representations or implications that are likely to cause the average person to misunderstand or be deceived.

Competition—Some competitive practices accepted in ordinary commercial and industrial enterprises—where profit-making is the primary objective—are inappropriate among physicians. Commercial enterprises, for example, are free to solicit business by paying commissions. They have no duty to lower prices to the poor. Commercial enterprises are generally free to engage in advertising "puffery," to be boldly self-laudatory in making claims of superiority, and to emphasize favorable features without disclosing unfavorable information.

Physicians, by contrast, have an ethical duty to subordinate financial reward to social responsibility. A physician should not engage in practices for pecuniary gain that interfere with his medical judgment and skill or cause a deterioration of the quality of medical care. Ability to pay should be considered in reducing fees, and excessive fees are unethical.

Physicians should not pay commissions or rebates or give kickbacks for the referral of patients. Likewise, they should not make extravagant claims or proclaim extraordinary skills. Such practices, however common they may be in the commercial world, are unethical in the practice of medicine because they are injurious to the public.

Freedom of choice of physician and free competition among physicians are prerequisites of optimal medical care. The *Principles of Medical Ethics* are intended to curtail abusive practices that impinge on these freedoms and exploit patients and the public.

Proceedings

Special Session of the House of Delegates

Camp Hill, JULY 11, 1976

(Secretary's Note: Affirmative action by the House on the recommendations of the Reference Committee was taken unless otherwise specifically reported.)

The House is Called to Order, July 11, 1976

The Speaker, John B. Lovette, M.D., called the House to order at 9:08 a.m., Sunday, July 11, 1976, in the Grand Ballroom of the Penn Harris Motor Inn, Camp Hill. The Chair called on Robert S. Sanford, M.D., a past president of the Pennsylvania Medical Society, who offered the invocation. The Speaker then called on David A. Smith, M.D., Dauphin County, chairman of the Committee on Credentials, who reported that a quorum was present.

Report of Committee on Rules

John L. Kelly, M.D., Delaware County, chairman of the Committee on Rules, presented the following report: "Mr. Speaker, and members of the House of Delegates:

"The Committee on Rules has met and heard no objection to the standing rules as presented in the delegates' packet, and I move the acceptance of these Standing Rules as promulgated in the delegates' packet."

Standing Rule No. 1—Order of Business, Special Session

The meeting of the House shall contain the items listed below, with the understanding that the Speaker may determine their order.

1. Call to Order
2. Invocation
3. Credentials Committee Report
4. Report of Committee on Rules
5. Announcements
6. Address by Dr. Masland
7. Introduction of Report of Board of Trustees and Councilors
8. Introduction of other business
9. Reference Committee Hearing
10. Report of Reference Committee
11. Announcements
12. Adjournment

Standing Rule No. 2—Procedure for Submitting Resolutions

As mandated in Section 3 of Article VII of the Constitution, Resolutions submitted for consideration by the Special Session of the House of Delegates must pertain to the matter expressly stated in the Call for the Special Session. This Special Session is called to consider recommenda-

tions concerning the creation of a captive insurance company. The recommendations for action are contained in the Report of the Board of Trustees. In addition to the recommendations by the Board, some counties may see the need for the embodiment of specific recommendations, and Resolutions which specifically address some aspect of the creation of an insurance company will be accepted for consideration by the House.

Such Resolutions must be introduced by a member of the House of Delegates acting in his own behalf or for the component county medical society or specialty he represents. Resolutions submitted prior to the opening of the House will require a two-thirds favorable vote to become the business of the House; those submitted after the House has convened will require a three-fourths vote.

Resolutions emanating from, and approved by, the Board of Trustees may be submitted directly to the House of Delegates at any time prior to or during the session, at the discretion of the Speaker.

All resolutions are to be submitted to the Secretary of this Society in duplicate and should include the name of the author.

The Speaker of the House of Delegates during the session of the House shall have the right to declare any resolution out of order in accordance with the principles of Sturgis Standard Code of Parliamentary Procedure.

Standing Rule No. 3

The legal counsel and the executive vice president of this Society, or their designated representatives, shall review without the right of censorship each reference committee report and inform the chairman of the reference committee and the Speaker of any possible implicating statements or recommendations. This rule shall not prevent a reference committee from submitting any reports that it deems proper.

Standing Rule No. 4—Actions of House in Effect until altered by House

Any resolution or other action of this House of Delegates shall remain in effect until countermanded or altered by the House of Delegates unless otherwise specified in the body of the original action taken by the House of Delegates.

Standing Rule No. 5

At the option of the Speaker, the Chair will not recognize the motion to vote immediately or terminate debate as being "in order" if it is added at the conclusion of a significant discussion of the immediately pending question, or at least until one additional person waiting to speak has also had the opportunity to discuss the immediately pending question. Therefore, if the request to terminate debate is made at the conclusion of a significant discussion and declared "out of order" the motion would be considered "in order" after the opportunity had been given for at least one additional speaker of opposite persuasion to discuss the immediately pending question, in order for the House to hear both sides of every issue which comes to the floor for consideration.

Announcements

Dr. Lovette drew the attention of the House to the membership of Reference Committee A, as reported on a list contained in the delegates' packet. He pointed out that Milton M. Perloff, M.D., was added as a member of the Reference Committee and would be seated at the front of the auditorium with the Reference Committee.

Address of the President

David S. Masland, M.D., Cumberland County, president, gave a thorough report on the background of the professional liability insurance crisis and reviewed how creation of a captive insurance company under the auspices of the Pennsylvania Medical Society fits in as part of an overall solution to the problem. He cautioned the House that creation of the captive company would solve only the availability problem and that basic tort reform is still necessary to change the underlying causes of the professional liability crisis. (Dr. Masland's address appears elsewhere in this issue of PENNSYLVANIA MEDICINE.)

Reading of Official Call

Dr. Lovette reviewed the Official Call to this special session of the House of Delegates, as contained in a letter from Dr. Winfield Yarnall, dated June 1, 1976. This letter stated in part, "the Board of Trustees and Councilors of the Pennsylvania Medical Society determined on May 19 to call a Special Session of the House of Delegates. The subject of this session will be the malpractice insurance crisis, specifically, and recommendations concerning the creation of a captive insurance company."

Dr. Lovette emphasized the Chair's intention to keep this limitation in mind; that this special session is devoted exclusively to consideration of the creation of a captive insurance company, and debate will be limited to that topic.

Acceptance of Reports and Resolutions

The report to the Special Session of the House of Delegates submitted by the Board of Trustees and Councilors, June 11, 1976, as contained in the delegates' packet, was accepted as the official business of the House.

Acceptance of Resolutions

The following resolutions were received for submission

to the special session and, as specified in Standing Rule No. 2, required a two-thirds vote to be introduced as the business of the House.

Resolution 76-S-1: Limitation of Membership of Captive Insurance Company to PMS Members.

(Secretary's Note: After the Resolution was read, the author of the Resolution asked that it be altered by the addition of the words "if legal" immediately after the word "that" in the first line of the resolved clause. The resolved clause as accepted for business of the House read: "RESOLVED, That if legal PMS membership be stipulated for participation in the Company.")

Resolution 76-S-2: Professional Liability Insurance Policy.

(Secretary's Note: The above-listed resolutions received the necessary two-thirds vote and were accepted as business of the House.)

Recess

Following the introduction of the resolutions, the Chair announced that the House would be put into recess and reconvene immediately for the Reference Committee Hearing.

Report of Reference Committee A

The Speaker recognized Ralph J. Stalter, M.D., Allegheny County, chairman of the Reference Committee. He presented the following report of the committee:

"Mr. Speaker and members of the House of Delegates: Reference Committee A has considered the three resolutions listed in the above index."

Report of the Board of Trustees and Councilors

(Secretary's Note: The Resolution presented in the Board Report reads:)

WHEREAS, on May 19, 1976, the Board of Trustees and Councilors authorized the organization of a stock casualty insurance company to write medical professional liability insurance and authorized the payment to the company of FIFTEEN THOUSAND DOLLARS (\$15,000.00) as an initial deposit on account of capital and surplus; and

WHEREAS, the Pennsylvania Medical Society caused Pennsylvania Medical Society Liability Insurance Company (Company) to be organized under the laws of the Commonwealth of Pennsylvania; and

WHEREAS, the Board of Trustees and Councilors has referred to this House of Delegates for consideration of the aforesaid action to be adopted, endorsed, modified, or rejected;

RESOLVED, that incorporation of Pennsylvania Medical Society Liability Insurance Company and the payment to the Company of FIFTEEN THOUSAND DOLLARS (\$15,000.00) on account of capital and surplus be and it is hereby approved and adopted; and be it further

RESOLVED, that appropriate officers of this Society be and they are hereby authorized to pay an additional ONE HUNDRED THIRTY-FIVE THOUSAND DOLLARS (\$135,000.00) to the Company for capital and surplus and to otherwise complete the organization of the Company; and be it further

RESOLVED, that appropriate officers of this Society be

and they are herein authorized on behalf of this Society to do any and all necessary proper additional acts to give effect to and implement the intent of this resolution.

"Mr. Speaker, your Reference Committee heard extensive testimony in strong support of the Board's Report and no substantive testimony against. Your Reference Committee believes this is due in large measure to the generous amount of time and energy which was expended by the Board of Trustees and staff in the preparation of this material.

Mr. Speaker, your Reference Committee recommends approval of the resolution contained in the Report of the Board of Trustees."

Resolution 76-S-1

Subject: Limitation of Membership in Captive Insurance Company to PMS Members

Author: Samuel S. Faris, M.D., Montgomery County Medical Society

Introduced by: Samuel S. Faris, M.D., Montgomery County Medical Society

WHEREAS, the Pennsylvania Medical Society Professional Liability Insurance Company is a product of the energy, wit, and treasure of the Pennsylvania Medical Society; therefore be it

RESOLVED, that if legal PMS membership be stipulated for participation in the Company.

"Mr. Speaker, your Reference Committee concurs with the intent of Resolution 76-S-1. However, it was believed that the resolution as written is unduly restrictive to the Board in its efforts to implement the intent of this resolution.

"Additionally, the Reference Committee considers that the final resolve of the Board of Trustees' Resolution provides adequate authorization for the Board of Directors to pursue the various possibilities which would allow implementation of the intent of this resolution.

Mr. Speaker, your Reference Committee recommends rejection of Resolution 76-S-1."

(Secretary's Note: The Recommendation was amended to approve Resolution 76-S-1 in principal and refer to the Board of Trustees for action. The Recommendation of the Reference Committee passed as amended.)

Resolution 76-S-2

Subject: Professional Liability Insurance Policy

Author: Allen S. Weed, M.D., Montgomery County Medical Society

Introduced by: Allen S. Weed, M.D., Montgomery County Medical Society

WHEREAS, the Pennsylvania Medical Society is contemplating the formation of a Pennsylvania Medical Society Liability Insurance Company; and

WHEREAS, the House of Delegates is being asked to delegate many decisions to the Board of Directors of the said company; and

WHEREAS, some physicians have expressed emphatic feelings about the type of professional liability insurance policies to be offered by the proposed captive PMS Insurance Company; therefore be it

RESOLVED, that the House of Delegates specifically

enjoin the proposed Board of Directors of the proposed Pennsylvania Medical Society Liability Insurance Company from issuing a claims made type of policy and that they be restricted to the consideration and issuance of an occurrence type policy.

"Mr. Speaker, your Reference Committee believes that the weight of the testimony heard on this Resolution favors the offering of both occurrence and claims made professional liability insurance coverage. The Reference Committee considers that Resolution 76-S-2, as written, eliminates that possibility.

"Therefore, Mr. Speaker, your Reference Committee felt it would be appropriate to offer the following substitute resolution:

"RESOLVED, that the House of Delegates authorize the proposed Board of Directors of the proposed Pennsylvania Medical Society Liability Insurance Company to consider marketing both occurrence and claims made policy forms.

"Mr. Speaker, your Reference Committee recommends rejection of Resolution 76-S-2 and adoption of the substitute resolution."

(Secretary's Note: An amendment from the floor was offered that the last word of the substitute resolution "forms" be deleted and replaced with the word "types."

The substitute Resolution then reads:

"RESOLVED that the House of Delegates authorize the proposed Board of Directors of the proposed Pennsylvania Medical Society Liability Insurance Company to consider marketing both occurrence and claims made policy types."

(Secretary's Note: The substitute Resolution was adopted as amended.)

Announcements

The Speaker expressed the gratitude of the House to the Reference Committee for its work in preparing the report.

The Speaker announced that a meeting of the Committee to Study Physicians' Unions would be held in Room Keystone A.

The Speaker requested delegates to drop their badges in the appropriate boxes at the rear of the auditorium so that they could be recycled.

David S. Cristol, M.D., Philadelphia County, took the floor to express the thanks of the House for the expeditious conduct of the meeting and the way the Speaker and Vice Speaker presided over the meeting. The House expressed its appreciation by applause.

Adjournment

It was properly moved and seconded that the Special Session of the House of Delegates adjourn. The motion passed by acclamation. The Special Session of the House of Delegates adjourned at 2:50 p.m.

Respectfully submitted,

John B. Lovette, M.D., Speaker
D. Ernest Witt, M.D., Vice Speaker
G. Winfield Yarnall, M.D., Secretary
John C. Rogalski, Assistant Secretary

Pennsylvania Guide to Continuing Medical Education



Prepared by:
Council on Education and Science
20 Erford Road, Lemoyne, Pennsylvania 17043
(717) 238-1635

This list of continuing medical education announcements is published as a supplement to the September and January issues of PENNSYLVANIA MEDICINE. It includes all intermittent programs, courses, seminars, lectures, and other continuing medical education activities that were reported prior to the deadline. Items received after the deadline will be published (if presentation date has not passed) in the next supplement. For a reprint of this supplement or for submitting additional announcements, contact the Council on Education and Science at the address shown above.

In most cases, each of the continuing medical education activities listed in this supplement has been granted AAFP and ACGP (osteopathic) credit. Contact those offices for details.

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General Abbreviations:

Acad Academy
Admin Administrator
Amer American
Assn Association
Ave(s) Avenues(s)
Bd Board
Blvd Boulevard
Bldg Building
Cntr Center
Chrm Chairman
Clin Clinic, Clinical
Co County
Coll College
Comm Committee
Cmsn Commission
Cont Continuing
CME Continuing Medical Education
Dept Department
Dir Director
DME Director Medical Education
Dist District
Div Division
Dr Drive
E East
Educ Education
Exec Executive

Gen General
Grad Graduate
Hosp Hospital
Inst Institute
Lab(s) Laboratory, Laboratories
Med Medical, Medicine
Mem Memorial
Natl National
N North
Pkwy Parkway
Phys Physicians
Pa Pennsylvania
Box Post Office Box
Prac Practice
Prof Professional
Prgm Program
RMP Regional Medical Program
Rehab Rehabilitation
Rd Road
Rm Room
Sch School
Secy Secretary
Serv Service
Soc Society
S South
St State, Street, Saint
Surg(s) Surgeon(s)
Univ University
VA Veterans Administration
W West

REFERENCE CODE FOR ACCREDITED PENNSYLVANIA INSTITUTIONS

(Each of the following institutions has continuing medical education accreditation to grant Category One Credit.)

Note: When any of these names appear in individual announcements, the code name (rather than full name) is printed. Refer to this section for address.

ACC—Amer. Coll. of Card., 9650 Rockville Pike, Bethesda, MD 20014
ACP—Amer. Coll. of Phys., 4200 Pine St., Philadelphia 19104
ACS—Amer. Coll. of Surgs., 55 E. Erie St., Chicago, Ill. 60610
AHA—Amer. Heart Assn., Pa. Affiliate, P.O. Box 2435, Harrisburg 17105
Allegheny—Allegheny Gen. Hosp., 320 E. North Ave., Pittsburgh 15212
Allergy—Pa. Allergy Assoc., 240 N. 36th St., Camp Hill 17011
AMA—Amer. Med. Assn., 535 N. Dearborn St., Chicago, Ill. 60610
Anesthesiologists—Pa. Soc. of Anesthesiologists, 20 Erford Rd., Lemoyne, 17043
Cambria-Somerset—Cambria-Somerset Reg. Council for Prof. Ed., % Lee Hosp., 320 Main St., Johnstown 15901
Chester—Chester Co. Hosp., 602 E. Marshall St., West Chester 19380 (% Joseph L. Abbott, M.D.)
Clin. Path.—Pa. Assn. of Clin. Path., 1735 W. Main St., Norristown 19401
Clin. Sch.—Clin. Sch. of the Family Inst., Wurzel Bldg., Philadelphia Psychiatric Cntr., Ford Rd. and Monument Ave., Philadelphia 19131
Coatesville—Coatesville Hosp., Coatesville 19320
Coatesville VA—Coatesville Vet. Admin. Hosp., Coatesville 19320
Coll. Phys./Phila.—Coll. of Phys. of Philadelphia, 19 S. 22nd St., Philadelphia 19103
Colon and Rectal—Pa. Soc. of Colon and Rectal Surg., Liberty Sq. Med. Cntr., 17th and Liberty Sts., Allentown 18104
Conemaugh—Conemaugh Valley Memorial Hosp., 1086 Franklin St., Johnstown 15905
Delaware Co.—Delaware Co. Mem. Hosp., Lansdowne Ave., Drexel Hill 19026
Dermatology—Pa. Acad. of Dermatology, 8220 Castor Ave., Philadelphia 19152 (% Charles H. Greenbaum, M.D.)
Elwyn—Elwyn Institute, 111 Elwyn Rd., Elwyn 19063
EPPI—Eastern Pa. Psychiatric Institute, Henry Ave. and Abbottsford Rd., Philadelphia 19129
Erie PG—Erie Postgraduate Med. Inst., Gannon Coll., Erie 16501
Frankford—Frankford Hosp., Frankford Ave. and Wakeling St., Philadelphia 19124
Geisinger—Geisinger Med. Cntr., Danville 17821
Hahnemann—Hahnemann Med. Coll., 230 N. Broad St., Philadelphia 19102
Hamot—Hamot Med. Cntr., Erie 16512
Harrisburg—Harrisburg Hosp., Harrisburg 17101
M. S. Hershey—Pa. State Univ. Coll. of Med., M. S. Hershey Med. Cntr., Univ. Dr., Hershey 17033
Institute—Institute of the Pa. Hosp., 111 N. 49th St., Philadelphia 19139
Jeanes—Jeanes Hosp. of Fox Chase Center for Cancer and Med. Sciences, 7600 Central Ave., Philadelphia 19111
Jefferson—Jefferson Med. Coll. 1025 Walnut St., Philadelphia 19107
Lackawanna Co.—Lackawanna Co. Med. Soc., Med. Arts Bldg., 327 N. Washington Ave., Scranton 18503
Lebanon VA—Lebanon Vet. Admin. Hosp., Lebanon 17042
Lehigh AHEC—Lehigh Valley Area Health Ed. Cntr. 335 N. Eighth St., Allentown 18102
McKeesport—McKeesport Hosp., 1500 5th Ave., McKeesport 15132
MCP—Med. Coll. of Pa., 3300 Henry Ave., Philadelphia 19129
Mercy/Pgh.—Mercy Hosp., Pride & Locust Sts., Pittsburgh 15219
Norristown State—Norristown State Hosp., Stanbridge & Sterigere Sts., Norristown 19141
Packer—Robert Packer Hosp., Sayre 18840
PAFP—Pa. Acad. of Family Phys., 5600 Derry St., Harrisburg 17111
Paoli—Paoli Mem. Hosp., Paoli 19301
PAO/O—Pa. Acad. of Oph. & Otol., 1248 Hamilton St., Allentown 18102
PMS—Pa. Med. Society, 20 Erford Rd., Lemoyne 17043
Phoenixville—Phoenixville Hosp., 140 Nutt Rd., Phoenixville 19460
Polyclinic—Harrisburg Polyclinic Hosp., Third St. and Polyclinic Ave., Harrisburg 17105
Psychiatry—Pa. Psychiatric Soc. 20 Erford Rd., Lemoyne 17043
Radiology—Pa. Radiological Soc., 20 Erford Rd., Lemoyne 17043
Reading—Reading Hosp., 6th Ave. & Spruce St., Reading 19602
St. Francis—St. Francis Gen. Hosp., Penn Ave. and 45th St., Pittsburgh 15201
St. Margaret—St. Margaret Mem. Hosp., 265-46th St., Pittsburgh 15201
St. Vincent—St. Vincent Hosp., Erie 16512
Temple—Temple Univ. Health Sciences Cntr., 3400 N. Broad St., Philadelphia 19140
U. of Pa.—Univ. of Pa. Sch. of Med., 288 Med. Labs. Bldg., Philadelphia 19174
Pitt—Univ. of Pittsburgh Sch. of Med., 1022-H Scaife Hall, Pittsburgh 15261

Roentgen Ray—Phila. Roentgen Ray Soc., Temple U. Health Sciences Cntr., Philadelphia 19140

Warren State—Warren St. Hosp., Box 249, Warren 16365

Washington—Washington Hosp., 155 Wilson Ave., Washington 15301

Wernersville—Wernersville St. Hosp., Wernersville 19565

West Penn—Western Pa. Hosp., 4800 Friendship Ave., Pittsburgh 15224

York—York Hosp., George St. & Rathton Rd., York 17405

ANNOUNCEMENTS

For more information, such as: frequency of sessions, fees, maximum registration, faculty, etc., contact the director at the address given in the announcement or in the REFERENCE CODE box on the cover.

Abington: Abington Mem. Hosp., '76-'77 Academic Year

(1) Grand Rounds, by **Temple**, second and fourth Tuesdays, Sept.-May (77-1-3)
Contact: Charles H. Ewing, M.D., Dir. of Cont. Educ., Abington Mem. Hosp., Abington 19001

Allentown: Allentown-Sacred Heart Hosps., '76-'77 Academic Year

(1) Continuing Medical Education Seminars, by **U. of Pa.**, bimonthly, Sept. 8-June 22 (77-1-39)
Contact: Fred Fister, M.D., Allentown Hosp., 17th and Chew Sts., Allentown 18102

Allentown: **PAO&O**, '76-'77 Academic Year

(1) Annual Conference on Pediatric Ophthalmology-Complications, at Hyatt House, Cherry Hill, N.J., May 15-17 (77-1-70)

(1) Annual Convention, at Bedford Springs Hotel, May 19-21 (77-1-71)

(1) Eye, Ear, Nose, and Throat Conferences, at Wyomissing Club, Reading, one day a month, Sept.-Apr. (77-1-72)

(1) Oculo-Plastic Surgery, at Bellevue-Stratford Hotel, Philadelphia, April 29-30 (77-1-73)

(1) The Glaucoma Patient, at Wills Eye Hosp., Philadelphia, April 1-2 (77-1-74)

(1) Retinal Diseases of the Young and Adolescent, at Marriott Hotel, Philadelphia, March 4-5 (77-1-75)

(1) Otolaryngology Conference, at Allegheny Co. Med. Soc. Headquarters, Pittsburgh, monthly Sept.-March (77-1-76)

(1) Ophthalmology Conferences, at Inter County Ophthalmologic Society, Lansdale, monthly, exact dates to be announced (77-1-77)

Contact: Robert E. Shoemaker, M.D., Chrm., Comm. on Scientific Work, **PAO&O**

Ambler: Horsham Hosp., '76-'77 Academic Year

(1) Discussion of Unusual and/or Complicated Cases, by **Temple**, bimonthly, Sept.-June (77-1-95)

(1) Clinical Case Conference/or Special Guest Lecture, by **Temple**, quarterly, Sept.-June (77-1-178)

Contact: Nicholas C. Tenaglia, M.D., Clin. Dir., Horsham Hosp., Welsh Rd. and Butler Pike, Ambler 19002

Bethlehem, Holiday Inn East, 1976

(1) What's New in Bronchial Asthma, by **Lehigh AHEC** and Lehigh Valley Tuberculosis and Health Assoc., Nov. 13 (76-2-68)

Contact: Jack Ryan, M.D., Pgm. Chm., St. Luke's Hosp., Bethlehem 18017

Bethlehem, St. Luke's Hosp., '76-'77 Academic Year

(1) Continuing Medical Education Program, by **MCP**, monthly, July-June (77-1-220)

Contact: Gerald H. Escovitz, M.D., Assoc. Dean for Cont. Educ., **MCP**

Bridgeville, Mayview State Hosp., '76-'77 Academic Year

(1) Drug Therapy for the Geriatric Patient, by **Pitt**, Sept. 14 (76-2-125)

Key to symbols:

() Numbers in parentheses at the beginning of an announcement indicate the PRA Category number in which attendance at this program should be reported. You may report each hour of attendance.

(76-1-XX) Numbers in parentheses at the end of an announcement are code numbers which will be helpful as a cross reference from the Subject Index section of this supplement.

Bold Face Type indicates an institution that has Category I accreditation. This name MUST APPEAR on your PRA APPLICATION to the AMA if you are to receive Category I credit.

(1) Leukemia, by **Pitt**, Oct. 12 (76-2-126)

(1) Diarrhea, by **Pitt**, Nov. 9 (76-2-127)

(1) Stasis Ulcer, by **Pitt**, Dec. 14 (76-2-128)

Contact: Robert Trivus, M.D., Superintendent, Mayview St. Hosp., Bridgeville 15017

Brownsville: Brownsville Gen. Hosp., '76-'77 Academic Year

(1) Continuing Education for Physicians, by **Pitt**, bimonthly, Oct.-May (77-1-290)

Contact: Thomas E. Park, M.D., Chief of Med. Staff, Brownsville Gen. Hosp., Simpson Rd., Brownsville 15417

Bryn Mawr: Bryn Mawr Hosp., '76-'77 Academic Year

(1) Interdepartmental Clinical Course, by **Jefferson**, monthly, Sept.-Sept. (77-2-2)

(1) Tumor Board, by **Jefferson**, weekly, Sept.-Aug. (77-1-30)

(1) Correlated Clinical Science Course-Surgery, by **Jefferson**, monthly, Sept.-June (77-1-31)

(1) Correlated Clinical Science Course-Pediatric, by **Jefferson**, monthly, Oct.-June (77-1-32)

(1) Correlated Clinical Science Course-Medicine, by **Jefferson**, monthly, Sept.-May (77-1-33)

(1) Correlated Clinical Science Course-Psychiatry, by **Jefferson**, monthly, Oct.-June (77-1-34)

Contact: Theodore J. Berry, M.D., DME, Bryn Mawr Hosp., Bryn Mawr, 19010

Butler: Butler Co. Med. Soc., '76-'77 Academic Year

(1) Continuing Education for Physicians, by **Pitt**, monthly, Sept.-May (77-1-284)

Contact: S. A. Nallathambi, Pgm. Chm., Butler Co. Med. Soc., Butler 16001

Canonsburg: Canonsburg Gen. Hosp., '76-'77 Academic Year

(1) Continuing Education for Physicians, by **Pitt**, monthly, Sept.-May (77-1-286)

Contact: Louis Signorella, M.D., Canonsburg Gen. Hosp., Canonsburg 15317

Carnegie: Woodville State Hosp., '76-'77 Academic Year

(1) Continuing Education Seminars, by **Pitt**, weekly, Sept.-June (77-1-35)

Contact: Maurice S. Cerul, M.D., Dir. of Educ., Woodville State Hosp., Carnegie 15106

Danville: **Geisinger**, '76-'77 Academic Year

(1) 2nd Annual Arthritis Seminar, Sept. 15 (76-2-56)

(1) Retrieval, Management and Comprehensive Care of Patient with Chronic Obstructive Airway Disease, Sept. 24-25, at Sheraton Inn, Danville (76-2-57)

(1) Acute Stress Reactions; Crisis for Patient and Physician, Oct. 6 (76-2-58)

(1) Emergency Medicine Seminar, Oct. 20 (76-2-59)

(1) Issues and Answers in Medical Practice, Oct. 30-31; at Sheraton Inn, Danville (76-2-60)

(1) Current Problems in Neurology, Nov. 3 (76-2-61)

(1) Recent Advances in Pediatrics, Nov. 17 (76-2-62)

(1) Advances in Clinical Practice, Feb. 12-13; at Sheraton Inn, Danville (77-1-205)

(1) Hypertension, 1977, Feb. 23 (77-1-206)

(1) New Developments in Otolaryngology of Interest to Primary Care Physicians, Mar. 7 (77-1-207)

(1) High and Low Blood Sugars and What to do About Them, Mar. 16 (77-1-208)

(1) Immunology for the Practitioner, Mar. 30 (77-1-209)

(1) Practical Advances in Dermatology, Apr. 6 (77-1-210)

(1) Abdominal Diseases: The Internist and the Surgeon, Apr. 6 (77-1-211)

(1) Pulmonary Physiology Made Easy: A Guide to the Understanding of Pulmonary Function Testing, Apr. 20 (77-1-212)

(1) Hypothyroidism and Thyrotoxicosis, May 4 (77-1-213)

(1) Special Child Conference-9th Annual, May 7 (77-1-214)

(1) The Worried Well: Practical Approaches to Problem Patients, June 1 (77-1-215)

(1) The Significance of the Apical Systolic Murmur, June 8 (77-1-216)

(1) Office Gynecology, Sept. 29 (76-2-63)

(1) Gynecologic Endocrinology, every fourth Monday (77-1-261)

(1) Neurology-Neurosurgery Conference, every Monday (77-1-262)

(1) Head and Neck Tumor Conference, every Monday (77-1-263)

(1) Visiting Professor Program, every third Monday (77-1-264)

(1) Behavioral Science Lectures in Family Practice, every Monday (77-1-265)

(1) Pediatric Grand Rounds, second and fourth Tuesdays (77-1-266)

(1) Multidisciplinary Tumor Conference, first and third Tuesdays (77-1-267)

(1) Cardiovascular Hemodynamic Conference, every Wednesday (77-1-268)

(1) Pulmonary Physiology Conference, every Wednesday (77-1-269)

(1) Core Curriculum Lectures in Family Practice, every Wednesday (77-1-270)

(1) Emergency Medicine Lectures, every Wednesday (77-1-271)

(1) Combined Pediatric, OB/GYN Perinatal Conference, every third Thursday (77-1-272)

(1) Rehabilitation Medicine Teaching Program, first and third Thursdays (77-1-273)

(1) Chest Conference, every Thursday (77-1-274)

(1) Electrophysiology Conference, every Friday (77-1-275)

(1) Hospital Grand Rounds, every Friday (77-1-276)

(1) Internal Medicine Conference, every Tuesday, Wednesday, and Thursday (77-1-277)

(1) Dermatology Conference, every Monday, Thursday, and Friday (77-1-278)

(1) Updating Medical Urology, every Thursday (77-1-279)

(1) Urology Pathology Conference, every third Thursday (77-1-280)

(1) Urology Radiology, every Friday (77-1-281)

(1) Pediatric Teaching Conference, every Tuesday and every first, second, and fourth

Thursday (77-1-282)

(1) Dermatology Grand Rounds; every last Friday of month, Sept.-May (77-1-296)
Contact: Mildred K. Fleetwood, Ph.D., V. Chm., Educ. Cmte., **Geisinger**

Drexel Hill; **Delaware Co.**; '76-'77 Academic Year

(1) Monthly Medical Symposium; monthly, Sept. 14-June 7 (77-1-60)
(1) Saturday Multidisciplinary Conference; weekly, Sept. 4-June 25 (77-1-61)
(1) Pediatric Problems; twice monthly, Sept. 2-June 16 (77-1-62)
(1) Current Problems in Anesthesiology; weekly, Sept. 13-June 27 (77-1-63)
(1) Surgical Seminar; monthly, Sept. 28-Aug. 23 (77-1-64)
(1) Continuing Medical Education in Gynecology; monthly, Sept. 23-Aug. 25 (77-1-65)
(1) Clinical Pathological Conference; monthly, Sept. 14-June 14 (77-1-66)
(1) Urology-Renology Conference; monthly, Sept. 10-June 10 (77-1-67)
(1) Continuing Education in Electroencephalography; weekly, Sept. 3-June 24 (77-1-68)
(1) Tumor Conference; monthly, Sept. 15-Aug. 17 (77-1-69)
Contact: Donald V. Powers, M.D., DME, **Delaware Co.**

East Stroudsburg; Pocono Hosp.; '76-'77 Academic Year

(1) Continuing Medical Education Program; by **MCP**; monthly, Sept.-May (77-1-217)
Contact: Gerald H. Escovitz, M.D., Assoc. Dean for Cont. Educ., **MCP**

Gettysburg; Annie Warner Hosp.; 1976

(1) Current Medical Concepts; by **Polyclinic** (76-2-68)
Contact: Harrison F. Harbach, M.D., 525 W. Middle St., Gettysburg 17325

Greensburg; Centralized Hosp. Serv. of Westmoreland Co.; '76-'77 Academic Year

(1) Continuing Education for Physicians; by **Pitt**; monthly, Oct.-June (77-1-288)
Contact: Ira Schugar, Dir., Educ. and Training, Centralized Hosp. Serv. of Westmoreland Co., Greensburg 15601

Hanover; Hanover Gen. Hosp.; '76-'77 Academic Year

(1) Neonatal Problems; by **Harrisburg**; Sept. 15 (76-2-78)
(1) Pediatric Allergies and Skin Infections of Childhood; by **Harrisburg**; Oct. 14 (76-2-79)
(1) The Emotional and Hyperactive Child and Teenager; by **Harrisburg**; Nov. 11 (76-2-80)
(1) Learning Disabilities and Dyslexia; by **Harrisburg**; Dec. 15 (76-2-81)
(1) The Anemias; Primary, Secondary, and Genetic; by **Harrisburg**; Jan. 13 (77-1-328)
(1) Peripheral Vascular Disorders and Phlebo-embolic Disease; by **Harrisburg**; Feb. 16 (77-1-329)
(1) Acute Hemorrhagic Shock; by **Harrisburg**; Mar. 17 (77-1-330)
(1) Eye Problems in General Practice; by **Harrisburg**; Apr. 13 (77-1-331)
(1) The Collagen Diseases; by **Harrisburg**; May 11 (77-1-332)
(1) Radiologic and Nuclear Medicine in Diagnosis and Therapy: Mammography, Xerography, Thermography, and the EMI; by **Harrisburg**; June 16 (77-1-333)
Contact: Gabriel Zelesnick, M.D., Chm., Cont. Educ. Cmte., Hanover Gen. Hosp., 300 Highland Ave., Hanover 17331

Hazleton; Hazleton St. Gen. Hosp.; '76-'77 Academic Year

(1) Continuing Medical Education Seminars; by **U. of Pa.**; weekly, Sept. 16-May 19 (77-1-37)
Contact: Robert Gunderson, M.D., Hazleton St. Gen. Hosp., Northeastern Bldg., Hazleton 18201

Huntingdon; J. C. Blair Hosp.; 1976

(1) Cardiac Arrhythmias; by **Geisinger**; Sept. 28 (76-2-64)
(1) Cancer Chemotherapy; by **Geisinger**; Oct. 26 (76-2-65)
(1) Emergency Medicine; by **Geisinger**; Nov. 23 (76-2-66)
(1) Menstrual Irregularities and Contraception; by **Geisinger**; Dec. 14 (76-2-67)
Contact: Mildred K. Fleetwood, Ph.D., V. Chm., Educ. Cmte., **Geisinger**

Johnstown; **Conemaugh**; 1976

(1) Endocrinology; Sept. 27-Oct. 1 (76-2-29)
(1) Arthritis Day; Oct. 21 (76-2-30)
(1) Hypertension; Oct. 26 (76-2-31)
(1) Update on Psychotherapeutics for the Primary Care Physician; Nov. 16-17 (76-2-32)
Contact: John H. Moyer, M.D., D.Sc., **Conemaugh**

Kane; McKean Co. Med. Soc.; '76-'77 Academic Year

(1) Continuing Education for Physicians; by **Pitt**; monthly, Sept.-May (77-1-289)
Contact: Thomas Logio, M.D., Pgm. Chm., McKean Co., Med. Soc., Kane 16735

Kingston; Nesbitt Mem. Hosp.; '76-'77 Academic Year

(1) Acute and Chronic Liver Disease; by **Geisinger**; Sept. 9 (76-2-69)
(1) Medical Management of Acute Renal Failure; by **Geisinger**; Oct. 14 (76-2-70)
(1) Office Dermatology; by **Geisinger**; Nov. 11 (76-2-71)
(1) Parkinson's Disease-Office Management; by **Geisinger**; Jan. 13 (77-1-284)
(1) New Concepts-Management of Multiple Sclerosis; by **Geisinger**; Jan. 13 (77-1-284)
(1) New Aspects of Management and Treatment of Endometriosis; by **Geisinger**; Feb. 10 (77-1-285)
(1) Treatment and Management of Cervical Carcinoma; by **Geisinger**; Feb. 10 (77-1-285)

(1) New Management of Hypertension; by **Geisinger**; Mar. 10 (77-1-286)

(1) Basics and Clinical Application of Arterial Blood Gases; by **Geisinger**; Apr. 14 (77-1-287)

(1) Chemo and Cobalt Therapy in Oncology; by **Geisinger**; May 12 (77-1-288)

Contact: William H. Boyle, M.D., Nesbitt Hosp., Wyoming Ave., Kingston 18704

Kittanning; Armstrong Co. Mem. Hosp.; '76-'77 Academic Year

(1) Continuing Education for Physicians; by **Pitt**; bimonthly, Oct.-May (77-1-291)
Contact: Se Boo Kang, M.D., Chm., Cont. Educ. Cmte., Armstrong Co. Mem. Hosp., Kittanning 16201

Lancaster; Lancaster Gen. Hosp.; '76-'77 Academic Year

(1) Medical Grand Rounds; by **Temple**; weekly, July-June (77-1-6)
(1) Clinical Correlation in Family Med.; by **Temple**; bi-weekly, July-June (77-1-7)
(1) Program in Continuing Med. Educ.; by **Temple**; weekly, July-June (77-1-8)
(1) Scientific Program-Monthly Staff Meeting; by **Temple**; monthly, Sept.-June (77-1-9)
(1) Surgical Pathology Conference; by **Temple**; monthly, Sept.-Aug. (77-1-96)
(1) Radiology Conference; by **Temple**; weekly, Sept.-Aug. (77-1-97)
(1) Neuropsychiatric Staff; by **Temple**; monthly, Sept.-Aug. (77-1-98)
(1) Anesthesia Meeting; by **Temple**; monthly, Sept.-Aug. (77-1-99)
(1) Obstetrics and Gynecology Conference; by **Temple**; monthly, Sept.-Aug. (77-1-100)
(1) Surgical, Mortality and Morbidity; by **Temple**; monthly, Sept.-Aug. (77-1-101)
(1) Pediatric Conference; by **Temple**; monthly, Sept.-Aug. (77-1-102)
(1) Ophthalmology Meeting; by **Temple**; monthly, Sept.-Aug. (77-1-103)
(1) Medical Staff Meeting; by **Temple**; monthly, Sept.-June (77-1-104)
Contact: John H. Esbenschade, Jr., M.D., DME, Lancaster Gen. Hosp., 555 N. Duke St., Lancaster 17604

Latrobe; Latrobe Area Hosp.; '76-'77 Academic Year

(1) Postgraduate Seminars for Physicians; by **Jefferson**; monthly (77-2-1)
Contact: Joseph R. Govi, M.D., Latrobe Area Hosp., Latrobe 15650

McKeesport; McKeesport Hosp.; 1976

(1) Continuing Education for Physicians; by **Pitt**; weekly, Oct. 1-Nov. 19 (76-2-72)
Contact: Frank R. Bondi, M.D., McKeesport Hosp., McKeesport 15132

Monongahela; Monongahela Valley Hosp., Inc.; '76-'77 Academic Year

(1) Continuing Education for Physicians; by **Pitt**; monthly, Sept.-May; alternates between Charleroi Division and Monongahela Division (77-1-287)
Contact: Monongahela Valley Hosp., Inc., Monongahela Div., Monongahela 15063

Natrona Heights; Tri-Co. Branch Med. Soc.; '76-'77 Academic Year

(1) Continuing Education for Physicians; by **Pitt**; monthly, Sept.-May (77-1-295)
Contact: William Balash, M.D., Pgm. Chm., Tri-Co. Branch Med. Soc., c/o Allegheny Valley Hosp., Natrona Heights 15065

New Castle; Lawrence Co. Med. Soc.; '76-'77 Academic Year

(1) Continuing Education for Physicians; by **Pitt**; monthly, Sept.-May (77-1-293)
Contact: James N. Bower, M.D., Lawrence Co. Med. Soc., New Castle 16101

New Castle; Alternating Between Jameson Mem. Hosp. and St. Francis Hosp.; '76-'77 Academic Year

(1) Continuing Education for Physicians; by **Pitt**; monthly, Sept.-May (77-1-294)
Contact: Frank J. Altomare, M.D., St. Francis Hosp. of New Castle, New Castle 16101

New Kensington; Citizens Gen. Hosp.; 1976

(1) Continuing Education for Physicians; by **Pitt**; Sept. 7-Dec. 7 (76-2-74)
Contact: Walter Zuck, M.D., Pgm. Chm., Citizens Gen. Hosp., New Kensington 15068

Norristown; Montgomery Co. Med. Soc.; '76-'77 Academic Year

(1) Suburban Pathology Society Seminar; by **U. of Pa.**; 1st Wednesday ea. month, Oct.-May (77-1-26)
Contact: John J. McGraw, Jr., M.D., Bryn Mawr Hosp., Bryn Mawr 19010

Oil City; Venango Co. Med. Soc.; '76-'77 Academic Year

(1) Continuing Education for Physicians; by **Pitt**; monthly, Oct.-June; alternates among Franklin Hosp., Franklin; Oil City Hosp., Oil City; and Titusville Hosp., Titusville (77-1-285)
Contact: Robert M. Pilewski, M.D., 122 W. First St., Oil City 16301

Philadelphia; **ACC**; Oct. 11-13, 1976

(1) ECG Core Curriculum; at Holiday Inn (76-2-72)
Contact: Leonard S. Dreifus, M.D., Dir. of Card., Lankenau Hosp., Philadelphia 19151

Philadelphia; Albert Einstein Med. Cntr.-Northern Div.; 1976

(1) Neurology Grand Rounds; by **Temple**; weekly, all year long (76-2-2)
(1) Orthopedic Conference; by **Temple**; weekly, all year long (76-2-3)
Contact: Morton S. Mandell, M.D., Chm., Cont. Educ. SubCmte., Albert Einstein Med. Cntr., York and Tabor Rds., Philadelphia 19141

Philadelphia; **Dermatology**; 1976

(1) Advances in Dermatology, 1976, Sept. 16-19; at Univ. of Pa. Hosp. (76-2-69)
Contact: Joseph Witkowski, M.D., Sec.-Treas., **Dermatology**

Philadelphia, Episcopal Hosp.: '76-'77 Academic Year

- (1) Neurology Grand Rounds, by **Temple**, fourth Tues., Jan.-Dec. (76-2-8)
- (1) Neurosurgical Seminar, by **Temple**, every Tues., Jan. 6-Dec. 28 (76-2-9)
- (1) General Histopathology, by **Temple**, daily Mon.-Fri., Jan. 2-Dec. 31 (76-2-4)
- (1) Combined Surgery, Radiology, Pathology Conference, by **Temple**, Thurs., Jan. 6-Dec. 28 (76-2-5)
- (1) Ob-Gyn Pathology, by **Temple**, Tuesdays, Jan. 6-Dec. 28 (76-2-11)
- (1) Genito-urinary Pathology, by **Temple**, Wednesdays, Nov. 3-Dec. 29 (76-2-12)
- (1) Update in Neurology, by **Temple**, May 1977 (77-1-314)
- (1) New Approaches in Common Clinical Problems, by **Temple**, Sept. 15, 22, and 29 (76-2-77)
- (1) Gastroenterologic Problems for Physicians, by **Temple**, biweekly, Sept. 9-Aug. 25 (77-1-315)
- (1) Department of Medicine CPC Conference, by **Temple**, monthly, Sept. 15-May 17 (77-1-316)
- (1) Cardiac Catheterization, by **Temple**, weekly, Sept. 13-May 30 (77-1-317)
- (1) Clinical Cardiology, by **Temple**, weekly, Sept. 14-May 31 (77-1-318)
- (1) Hematology, by **Temple**, weekly, Sept. 27-June 27 (77-1-319)
- (1) Pulmonary Conference, by **Temple**, biweekly, Sept. 3-Aug. 19 (77-1-320)
- (1) Nephrology for the Practicing Physician, by **Temple**, biweekly, Sept. 14-Aug. 23 (77-1-321)
- (1) Department of Medicine Grand Rounds, by **Temple**, weekly, Sept. 17-May 29 (77-1-322)
- (1) Temple TV Grand Rounds, by **Temple**, weekly, Sept. 15-May 25 (77-1-323)
- (1) Endocrinology for the Practicing Physician, by **Temple**, biweekly, Sept. 2-Aug. 18 (77-1-324)

Contact: Jacob Zatuchni, M.D., Dept. of Med., Episcopal Hosp., Front St. and Lehigh Ave., Philadelphia 19125

- (1) Neuroradiology-Pathology, by **Temple**, Tuesdays, Jan. 27-Dec. 28 (76-2-10)
- (1) Radiology Conference, by **Temple**, weekly (76-2-13)
- (1) Surgery Rounds, by **Temple**, Tuesdays, Jan. 6-Dec. 28 (76-2-6)
- (1) Uroradiology Conference, by **Temple**, weekly (76-2-30)

Contact: LeRoy H. Stahlgren, M.D., Episcopal Hosp., Front St. and Lehigh Ave., Philadelphia 19125

- (1) Introductory Diagnostic Ultrasound, by **Temple**, Dec. 13-17 and Mar. 7-11 (77-1-105)
- (1) Diagnostic Ultrasound-Advanced Abdominal Scanning, by **Temple**, Jan. 10-14 and Apr. 18-22 (77-1-106)
- (1) Diagnostic Ultrasound-Echocardiography, by **Temple**, Feb. 14-18 and May 2-6 (77-1-107)
- (1) Diagnostic Ultrasound-Cross-Sectional Anatomy, by **Temple**, June 6-10 (77-1-108)

Contact: Albert J. Finestone, M.D., Ass't. Dean, **Temple**

Philadelphia, **EPPI**, '76-'77 Academic Year

- (1) Depression, Dec. 9 (76-2-33)
- (1) Medical or Psychiatric Problem? Exercises in Differential Diagnosis, weekly, Oct. 14-Nov. 18 (76-2-34)
- (1) The Long-Lived, Sept. 30 (76-2-35)
- (1) Pain Control: Medical, Psychological and Psychiatric Aspects, March 31 (77-1-79)
- (1) Schizophrenia, Jan. 13 (77-1-80)
- (1) Manic-Depressive Illness, Feb. 10 (77-1-81)

Contact: Geraldine DePaula, M.D., Dir., CME, **EPPI**

- (1) Introduction to Clinical Behavior Therapy, by **Temple**, weekly, Sept. 15-Mar. 30 (77-1-115)
- (1) The 12th June Institute in Behavior Therapy, by **Temple**, daily for 4 weeks, June 6-July 1 (77-1-116)

Contact: Albert J. Finestone, M.D., Asst. Dean, **Temple**

Philadelphia, Frankford Hosp.: '76-'77 Academic Year

- (1) Continuing Medical Education Program, by **MCP**, monthly, Sept.-June (77-1-218)

Contact: Gerald H. Escovitz, M.D., Assoc. Dean for Cont. Educ. **MCP**

Philadelphia, **Hahnemann**, '76-'77 Academic Year

- (1) The Current Techniques of Operative Neurosurgery, at the Bellevue-Stratford Hotel, Philadelphia, Nov. 29-Dec. 1 (76-2-49)
- (1) Advances in Diagnosis and Treatment of Neurological Disease, at the Bellevue-Stratford Hotel, Philadelphia, Sept. 13-15 (76-2-50)
- (1) Current Concepts in Medicine, Wednesdays, Oct. 6-May 18 (77-1-180)
- (1) Chairman's Medical Grand Rounds, Thursdays, Oct. 7-May 26 (77-1-181)
- (1) Clinical Skills for Physician Assistants IV, at Sheraton Hotel, Philadelphia, Oct. 10-13 (76-2-51)
- (1) Workshops in Respiratory Intensive Care, Oct. 11-22 (76-2-52)
- (1) Electrocardiography for the Practitioner, at Sheraton-Valley Forge Hotel, Valley Forge, Oct. 25-27 (76-2-53)
- (1) Pediatric Endoscopy, at College of Physicians, Oct. 28-30 (76-2-54)
- (1) Spectrum of Hypertensive Drugs, at Sheraton Hotel, Philadelphia, Nov. 8-9 (76-2-55)
- (1) Occupational Respiratory Disease, at Sheraton Hotel, Philadelphia, Feb. 21-23 (77-1-182)

- (1) Cancer Chemotherapy III, at Sheraton Hotel, Philadelphia, Apr. 18-20 (77-1-183)
- (1) Bedside Diagnosis of Heart Disease, at Marriott Motor Hotel, Philadelphia, July 18-20 (77-1-184)

- (1) Therapeutics, at Marriott Motor Hotel, Philadelphia, May 8-12 (77-1-185)
- (1) Rheumatology Tutorial Course, Monday and Thursday, Sept. 6-30; Oct. 4-29; Nov. 1-25; Jan. 3-27; Feb. 7-Mar. 3; Mar. 7-31; Apr. 4-28; May 2-26; June 6-30 (77-1-186)
- (1) Neuropathology Tutorial, Oct. 4-Dec. 24; Jan. 3-Mar. 25; Apr. 4-June 24 (77-1-187)
- (1) Adult Neurology Tutorial, Oct. 4-Dec. 24; Jan. 3-Mar. 25; Apr. 4-June 24 (77-1-188)
- (1) Pediatric Neurology Tutorial, Oct. 4-Dec. 24; Jan. 3-Mar. 25; Apr. 4-June 24 (77-1-189)
- (1) Fluid and Electrolyte Metabolism Tutorial, Sept. 6-17; Oct. 3-14; Nov. 7-18; Jan. 3-14; Feb. 7-18; Mar. 7-18; Apr. 4-15; May 2-13; June 6-17 (77-1-190)
- (1) Hypertension, Clinical and Laboratory Tutorial, Sept. 6-17; Oct. 3-14; Nov. 7-18; Jan. 3-14; Feb. 7-18; Mar. 7-18; Apr. 4-15; May 2-13; June 6-17 (77-1-191)
- (1) Dialysis Tutorial Course, Sept. 6-17; Oct. 3-14; Nov. 7-18; Jan. 3-14; Feb. 7-18; Mar. 7-18; Apr. 4-15; May 2-13; June 6-17 (77-1-192)
- (1) Gastrointestinal Endoscopy Tutorial, Sept. 13-17; Oct. 11-15; Nov. 8-12; Dec. 13-17; Jan. 10-14; Feb. 14-18; Mar. 14-18; Apr. 11-15; May 9-13; June 13-17 (77-1-193)
- (1) Clinical Gastroenterology Tutorial, weekly, Sept. 16-Oct. 20; Mar. 17-Apr. 21 (77-1-194)
- (1) Clinical Immunology Tutorial Course, Sept. 6-Oct. 29; Feb. 7-Apr. 1; May 2-June 24 (77-1-195)
- (1) Cardiac Care Unit Tutorial, Oct. 4-22; Oct. 25-Nov. 12; Jan. 3-21; Jan. 24-Feb. 11; Feb. 14-Mar. 4; Mar. 7-25; Apr. 11-29; May 2-20; May 23-June 10 (77-1-196)
- (1) Basic Medicine Tutorial Course, Sept. 13-Dec. 3; Jan. 10-Apr. 1; Apr. 4-June 24 (77-1-197)
- (1) Critical Care Tutorial Course, Nov. 1-Dec. 24; Jan. 3-Feb. 25; Mar. 7-Apr. 29; May 2-June 24 (77-1-198)
- (1) Continuing Education Program, weekly, Sept. 10-June 10 (77-1-199)
- (1) Continuing Education Program, weekly, Sept. 15-May 18 (77-1-200)
- (1) Continuing Education Program, weekly, Sept. 16-May 19 (77-1-201)
- (1) Continuing Education Program, weekly, Nov. 26-May 20 (77-1-202)
- (1) Continuing Education Program, weekly, Sept. 24-June 24 (77-1-203)
- (1) Continuing Education Program, weekly, Sept. 15-June 22 (77-1-204)

Contact: Robert J. Schaefer, Exec. Dir., Cont. Educ. Pgm. Coordinator, **Hahnemann**

Philadelphia, **Jeanes**, '76-'77 Academic Year

- (1) Breast Cancer Network, Sept. 2 and Oct. 2 (76-2-136)
- (1) Pathologists Meeting, March 3 and June 2 (77-1-82)
- (1) Radiology Conference, weekly, Sept. 2-Aug. 25 (77-1-83)
- (1) GI Conference, weekly, Sept. 3-Aug. 26 (77-1-84)
- (1) Cancer Detection in Office Practice, weekly, Sept. 8-May 25 (77-1-85)
- (1) Tumor Conference, weekly, Sept. 13-July 25 (77-1-86)
- (1) Tumor Board, weekly, Sept. 13-Aug. 29 (77-1-87)
- (1) Pathology Slide Conference, weekly, Sept. 14-Aug. 30 (77-1-88)
- (1) Weekly Scientific Conference, weekly, Sept. 15-May 18 (77-1-89)
- (1) Clinical Rounds, Medical Dept., weekly, Sept. 15-June 15 (77-1-90)
- (1) Common GI Problems in Office Practice, one day per week, Sept. 22-29 (76-2-137)
- (1) Medical Dept. Meeting, Scientific, monthly, Sept. 22-June 22 (77-1-91)
- (1) Surgical Dept. Meeting, Scientific, monthly, Oct. 6-Aug. 3 (77-1-92)
- (1) Common Urologic Problems in Office Practice, one day per week, Oct. 20-27 (76-2-138)
- (1) Symposium: Management of the Acute Critically Ill Patient, Nov. 17 (76-2-139)
- (1) Rheumatology for Practicing Physicians, one day per week, Jan. 19-26 (77-1-93)
- (1) Common Neurology Problems in Office Practice, one day per week, Apr. 20-27 (77-1-94)

Contact: Joseph M. Winston, M.D., Chm., Dept. of Medical Education, **Jeanes**

Philadelphia, **MCP**, '76-'77 Academic Year

- (1) Preceptorships for Practicing Physicians (in all sub specialties); scheduled as convenient (76-2-31)
- (1) Retraining Program for Inactive Physicians, Apr. 18-June 10 (77-1-221)
- (1) Radiation Oncology Conference, weekly (77-1-222)
- (1) Thyroid Conference, weekly (77-1-223)
- (1) Nuclear Medicine Conference, weekly (77-1-224)
- (1) Visiting Professor Program-Medicine, monthly (77-1-225)
- (1) Department of Medicine Grand Rounds, weekly (77-1-226)
- (1) Obstetrics-Gynecology Grand Rounds, weekly (77-1-227)
- (1) Emergency Medicine Grand Rounds, weekly (77-1-228)
- (1) IVP Conference, two days per month (77-1-229)
- (1) Angiography Conference, two days per month (77-1-230)
- (1) GI Conference, weekly (77-1-231)
- (1) Radiology Journal Club, two days per month (77-1-232)
- (1) Radiology-Pathology Conference, two days per month (77-1-233)
- (1) Morbidity and Mortality Rounds, weekly (77-1-234)
- (1) Neurology Grand Rounds, weekly (77-1-235)
- (1) Gross and Neuropathology Conference, weekly (77-1-236)
- (1) Neurology Journal Club, weekly (77-1-237)
- (1) Neurology Psychiatry Conference, monthly (77-1-238)
- (1) Rheumatology-Radiology Conference, twice monthly (77-1-239)
- (1) Rheumatology Quiz Review, weekly (77-1-240)
- (1) Rheumatology Visiting Professor Conference, weekly (77-1-241)
- (1) Rheumatology Grand Rounds, weekly (77-1-242)

(1) Orthopedic Anatomy Conference; weekly (77-1-243)
 (1) Orthopedic Sound Slide Series; weekly (77-1-244)
 (1) Orthopedic-Rheumatology Conference; monthly (77-1-245)
 (1) Orthopedic-Radiology Conference; weekly (77-1-246)
 (1) Orthopedic Grand Rounds; weekly (77-1-247)
 (1) Orthopedic-Pediatric Conference; monthly (77-1-248)
 (1) Pediatric Surgery Conference; monthly (77-1-249)
 (1) Pediatric Hematology Conference; monthly (77-1-250)
 (1) Pediatric Cardiology Conference; monthly (77-1-251)
 (1) Pediatric Grand Rounds; three times monthly (77-1-252)
 (1) Pediatric Pathology Conference; monthly (77-1-253)
 (1) Pediatric Neurology Conference; monthly (77-1-254)
 (1) Obstetrics-Pediatrics Conference; weekly (77-1-255)
 (1) Surgery Grand Rounds; weekly (77-1-256)
 (1) Surgery Conference; weekly (77-1-257)
 (1) Acute Care Conference; weekly (77-1-258)
 (1) Chest Conference; weekly (77-1-259)
 (1) Urology-Radiology Conference; weekly (77-1-260)
 Contact: Gerald H. Escovitz, M.D., Assoc. Dean for Cont. Educ., **MCP**

Philadelphia; Moss Rehabilitation Hosp., Albert Einstein Med. Cntr.; '76-'77 Academic Year
 (1) Grand Rounds; by **Temple**, weekly, Sept.-June (77-1-27)
 (1) Basic Science and Clinical Concept Review; by **Temple**, weekly, Sept.-June (77-1-28)
 (1) Prosthetics/Orthotics Conference; by **Temple**, weekly, July-June (77-1-29)
 Contact: Thomas E. Strax, M.D., Moss Rehab. Hosp., 12th St. and Tabor Rd., Philadelphia 19141

Philadelphia; Philadelphia Psych. Cntr.; '76-'77 Academic Year
 (1) Grand Rounds; by **Psychiatry**; Thurs., Sept. 9-June 23 (77-1-78)
 Contact: Harold Winn, M.D., Dir., CME, Phila. Psych. Cntr., Ford Road and Monument Ave., Philadelphia 19131

Philadelphia; St. Christopher's Hosp. for Children; '76-'77 Academic Year
 (1) Pediatric Cardiology Conference; by **Temple**, weekly, Sept.-June (77-1-109)
 (1) Pediatric Conference; by **Temple**, weekly, Sept.-June (77-1-110)
 (1) Grand Rounds; by **Temple**, weekly, Sept.-June (77-1-111)
 (1) Pediatric Radiology; by **Temple**, weekly, Sept.-June (77-1-112)
 (1) 26th Annual Seminar in Pediatrics; by **Temple**, at Benjamin Franklin Hotel, Philadelphia; June 7-10 (77-1-113)
 (1) A Day of Pediatric Nephrology; by **Temple**; Apr. 20 (77-1-114)
 Contact: Alan B. Gruskin, M.D., Dir., Cont. Educ., St. Christopher's Hosp. for Children, 2600 N. Lawrence St., Philadelphia 19133

Philadelphia; **Temple**; '76-'77 Academic Year
 (1) Monthly Medical Conference; at Northeastern Hosp., Phila.; monthly, Sept.-June (77-1-179)
 (1) Hepatology Conference; weekly, Sept.-June (77-1-119)
 (1) 2nd International Symposium on Planning of Radiological Depts.; at Benjamin Franklin Hotel, Philadelphia; Sept. 26-30 (76-2-140)
 (1) Pediatric Dermatology; at Benjamin Franklin Hotel, Philadelphia; Oct. 7-9 (76-2-141)
 (1) 3rd Annual Temple Conference on Behavior Therapy and Behavior Modification; at Hilton Hotel, Philadelphia; Oct. 7-10 (76-2-142)
 (1) Recent Advances in Medicine; weekly, Oct. 13-Dec. 1 (76-2-143)
 (1) 2nd Annual Weiss-English Psychosomatic Symposium; Oct. 30 (76-2-144)
 (1) 17th Annual Forman Course-Current Problems in Perinatology; Nov. 17 (76-2-145)
 (1) Surgical Symposium-Clinical Concepts of Breast Disease; Nov. 19-20 (76-2-146)
 (1) Minimal Brain Dysfunction in Children; at Marriott Motor Inn, Bala Cynwyd; Dec. 3-4 (76-2-147)

(1) Clinical Gastroenterology; at Hotel Rose Hall Inter-Continental, Montego Bay, Jamaica; Dec. 26-Jan. 2 (77-1-120)
 (1) The Practice of Behavior Therapy with Children: A Training Seminar; at Hilton Hotel, Philadelphia; Jan. 20-21 (77-1-121)
 (1) Workshop in Surgery of the Posterior Fossa; at Sheraton Airport Inn, Philadelphia; Jan. 22-23 (77-1-122)
 (1) A Day in Pediatric Cardiology; Mar. 16 (77-1-123)
 (1) Frontiers of Psychotherapy; at University City Holiday Inn, Philadelphia; Mar. 17-18 (77-1-124)
 (1) Urology Course; Mar. 21 (77-1-125)
 (1) Emergency Department Radiology; Apr. 13 (77-1-126)
 (1) Clinical Skills Day; at Sugarloaf Conference Center, Philadelphia; Apr. 23 (77-1-127)
 (1) Family Practice Review Course; at Landis Valley Motor Inn, Lancaster; Apr. 25-29 (77-1-128)
 (1) Stauffer Memorial Lecture; Apr. 27 (77-1-129)
 (1) Thrombosis Course; at Marriott Motor Inn, Bala Cynwyd; June 24-25 (77-1-130)
 (1) Mini Fellowships in Sports Medicine; date to be announced (77-2-9)
 (1) ENT Workshop; date to be announced (77-2-10)
 (1) Anesthesiology Basic Science Lecture; weekly, Sept.-June (77-1-131)
 (1) Anesthesiology Case Conference; weekly, Sept.-June (77-1-132)
 (1) Anesthesiology Seminar; weekly, Sept.-June (77-1-133)
 (1) Anatomy Conference and Class; weekly, Sept.-June (77-1-134)
 (1) Basic Science Review; weekly, Sept.-June (77-1-135)

(1) Thrombohemorrhagic Conference; weekly, Sept.-June (77-1-139)
 (1) Pulmonary Grand Rounds; weekly, Sept.-June (77-1-141)
 (1) Angiography; weekly, Sept.-June (77-1-136)
 (1) Cardiac Arrhythmia Conference; weekly, Sept.-June (77-1-137)
 (1) Cardiac Catheterization Conference; weekly, Sept.-June (77-1-138)
 (1) Chest Conference; weekly, Sept.-June (77-1-140)
 (1) Electrodiagnostic Rounds; weekly, Sept.-June (77-1-142)
 (1) Endocrine-Metabolic Conference; weekly, Sept.-June (77-1-143)
 (1) GI Conference; weekly, Sept.-June (77-1-144)
 (1) Medical Grand Rounds; weekly, Sept.-June (77-1-145)
 (1) CPC/Medicine; weekly, Sept.-June (77-1-146)
 (1) Fracture Conference; weekly, Sept.-June (77-1-147)
 (1) Rheumatology Conference; weekly, Sept.-June (77-1-148)
 (1) Infectious Disease Clinical Microbiology Conference; weekly, Sept.-June (77-1-149)
 (1) Neurology Conference; weekly, Sept.-June (77-1-150)
 (1) Grand Rounds in Neurosurgery; weekly, Sept.-June (77-1-151)
 (1) OB/GYN Grand Rounds; weekly, Sept.-June (77-1-152)
 (1) OB/GYN Postgraduate Program; weekly, Sept.-June (77-1-153)
 (1) Hematology-Oncology Conference; weekly, Sept.-June (77-1-154)
 (1) Tumor Conference; weekly, Sept.-June (77-1-155)
 (1) Orthopedic Surgery Basic Science Conference; weekly, Sept.-June (77-1-156)
 (1) Orthopedic Surgery Grand Rounds; weekly, Sept.-June (77-1-157)
 (1) Patient Care Mortality and Morbidity Conference; weekly, Sept.-June (77-1-158)
 (1) Grand Rounds in Psychiatry; weekly, Sept.-June (77-1-159)
 (1) Rehabilitation Chairman's Rounds; weekly, Sept.-June (77-1-160)
 (1) Clinical Pathology Radiology Conference; weekly, Sept.-June (77-1-161)
 (1) Neuroradiology Conference; weekly, Sept.-June (77-1-162)
 (1) Orthopedic Radiology; weekly, Sept.-June (77-1-163)
 (1) Urologic Radiology; biweekly, Sept.-June (77-1-164)
 (1) Surgical Morbidity Conference; weekly, Sept.-June (77-1-165)
 (1) Medical/Surgical Conferences; 2 days a week (77-2-11)
 (1) Grand Rounds from Temple Univ. School of Medicine, Wednesdays, Sept.-June (77-1-174)

(1) Chevalier Jackson Basic Course in Bronchoesophagology; Feb. 7-18 (77-1-176)
 (1) Medical and Psychiatry Continuing Education; at Allentown State Hosp.; Jan. 17, Feb. 28, Mar. 21, Apr. 18, May 16, and June 20 (77-1-177)
 (1) Dermatology Grand Rounds; weekly, Sept.-June (77-2-166)
 (1) Socratic Seminars; dates variable (77-2-12)
 (1) Journal Club; weekly, Sept.-June (77-1-166)
 (1) Basic Science Seminar; weekly, Sept.-June (77-1-167)
 (1) Progress in General Medicine-Toland Memorial Lecture; monthly, 3rd Wednesday, Sept.-June (77-1-168)
 (1) Grand Rounds; every 2nd and 4th Tuesday, Sept.-May (77-1-169)
 (1) Clinical Application of New Developments in Medicine; at Phila. State Hosp.; biweekly, Fridays, Sept.-Feb. (77-1-170)
 (1) Grand Rounds; at McShea Hall, Montgomery Hosp.; first Thurs. each month, Sept.-June (77-1-171)
 (1) Continuing Education Medical Conference; Fridays, Sept.-June (77-1-172)
 Contact: Albert J. Finestone, M.D., Assistant Dean, Cont. Med. Educ., **Temple**

Philadelphia; Union League; Sept. 17, 1976
 (1) Scientific Session; by **Colon and Rectal** (76-2-71)
 Contact: James A. Sheets, M.D., Sec., **Colon and Rectal**

Philadelphia; **U. of Pa.**; '76-'77 Academic Year
 (1) Primary Management of Radiation Injuries; Nov. 6, 1976 (76-2-79)
 (1) Department of Medicine Weekly Conferences; Sept.-June (77-1-36)
 Contact: Henry G. Sparks, Coordinator, Cont. Educ. Program, **U. of Pa.**

Philadelphia; West Park Hosp.; '76-'77 Academic Year
 (1) Continuing Medical Education Program; by **MCP**; monthly, Sept.-June (77-1-219)
 Contact: Gerald H. Escovitz, M.D., Assoc. Dean for Cont. Edu., **MCP**

Pittsburgh; **Allegheny**; '76-'77 Academic Year
 (1) Basic Science Clinical Correlation Lectures (Surgical); Wednesdays, Jan.-Dec. (76-2-74)
 (1) Case Presentation Seminar (Surgical); Mondays, Jan.-Dec. (76-2-78)
 (1) Selected Readings in General Surgery; Mondays, Jan.-Dec. (76-2-76)
 (1) Surgical Grand Rounds; Thursdays, Jan.-Dec. (76-2-75)
 (1) Weekly Case Review Conference (Surgical); Fridays, Jan.-Dec. (76-2-77)
 Contact: Reuben Zemel, M.D., Acting Head, Div. of Gen. Surg., **Allegheny**
 (1) Cardiology Conference; Mondays, Sept. 6-June 27 (77-1-17)
 Contact: Stanley Briller, M.D., Head, Heart Station, **Allegheny**
 (1) Endocrinology Conference; 2nd Thurs. each month, Sept. 9-June 9 (77-1-13)
 Contact: James Parrish, M.D., Head, Div. of Endocrin., **Allegheny**
 (1) Head and Neck Radiation Oncology Conference; Fridays, Sept. 3-June 24 (77-1-14)
 Contact: J. P. Concannon, M.D., Head, Div. of Radiation/Oncology, **Allegheny**
 (1) Hematology/Oncology Conference; Thursdays, Sept. 2-June 30 (77-1-23)
 Contact: Milton M. Michaels, M.D., Head, Div. of Hematology, **Allegheny**
 (1) Laboratory Medicine Seminar; 2nd Friday of each month, Sept. 10-June 10 (77-1-18)
 (1) Lecture Series in Pathology; last Friday of each month, Sept. 24-June 24 (77-1-22)

(1) Medical Mortality Conference; 1st and 3rd Friday of each month, Sept. 8-June 15 (77-1-21)
 (1) Pathology-Oncology Slide Seminar; weekly, Sept. 3-June 24 (77-1-20)
 Contact: Robert J. Hartsock, M.D., Dir., Dept. of Lab. Med., **Allegheny**
 (1) Neurology Section of Internal Medicine Conference; 3rd Thurs. of each month, Sept. 16-June 16 (77-1-15)
 Contact: Hirsh Wachs, M.D., Head, Div. of Neurol., **Allegheny**
 (1) Neurosciences Conference; Fridays, Sept. 3-June 24 (77-1-16)
 Contact: Emil H. Schnap, M.D., Div. of Diag. Rad., **Allegheny**
 (1) Nuclear Medicine Lectures; weekly, Sept. 6-June 27 (77-1-24)
 Contact: Mustafa H. Adatepe, M.D., Head, Sect. of Nuclear Med., **Allegheny**
 (1) Obstetrics/Gynecology Conference; Thurs., Sept. 9-June 30 (77-1-10)
 Contact: James Gilmore, M.D., Chmn., Dept. of OB/GYN, **Allegheny**
 (1) Pathology-Radiology Correlation Conference, Tues., Sept. 7-June 28 (77-1-11)
 Contact: John H. Feist, M.D., Pgm. Dir., Div. of Diag. Rad., **Allegheny**
 (1) Renal-Electrolyte Conference; 4th Thurs. each month, Sept. 23-June 23 (77-1-12)
 Contact: Jules B. Puschett, M.D., Head, Div. of Renal-Elect. Dis., **Allegheny**
 (1) Thoracic Surgery Conference; weekly, Sept. 7-June 28 (77-1-19)
 Contact: George J. Magovern, M.D., Dept. of Surg., **Allegheny**

Pittsburgh; Mercy, '76-'77 Academic Year

(1) Medical Grand Rounds; weekly, continual (76-2-17)
 (1) Medical Mortality Session; weekly, continual (76-2-18)
 (1) Neurology and Neurosurgery Conference; weekly, continual (76-2-19)
 (1) Otolaryngology Clinical Pathology Conference; monthly, continual (76-2-20)
 (1) Tumor Board, weekly, continual (76-2-21)
 (1) Pediatric Grand Rounds; weekly, continual (76-2-22)
 (1) Pediatric Conference; weekly, continual (76-2-23)
 (1) Surgical Mortality Session; weekly, continual (76-2-24)
 (1) General Surgical Conference; weekly, continual (76-2-25)
 (1) Anesthesiology Basic Science Lectures; weekly, August 25-June 22 (77-1-297)
 (1) Anesthesiology Resident Seminar; weekly, Sept. 2-June 23 (77-1-298)
 (1) Cardiology Conferences; weekly, Sept. 1-June 15 (77-1-299)
 (1) Combined Gastro-Surgical Conference; Sept. 8-May 25 (77-1-300)
 (1) Medical Quarterly Conference; Sept. 8, Dec. 8, Mar. 9, and June 8 (77-1-301)
 (1) Medical Resident Seminars; weekly, Sept. 4-June 25 (77-1-302)
 (1) Mercy Day Scientific Conference; Sept. 17 (76-2-26)
 (1) Gynecologic Endocrinology Lecture; Sept. 14-May 24 (77-1-303)
 (1) Obstetric/Gynecology Grand Rounds; weekly, Sept. 3-May 28 (77-1-304)
 (1) Gynecology/Pathology Conference; weekly (77-1-305)
 (1) Human Genetics; biweekly (77-1-306)
 (1) Joint Orthopedic Conference; biweekly, Sept. 7-May 24 (77-1-307)
 (1) Otolaryngology and Maxillofacial Conference; Sept. 4-June 25 (77-1-308)
 (1) Otolaryngology Conference; Sept. 2-June 24 (77-1-309)
 (1) Concepts in Soft Tissue Surgery; Jan. 24-28 (77-1-310)
 (1) Plastic Reconstructive Surgery Conference; weekly, Sept.-June (77-1-311)
 (1) Radiology-ENT Conference; monthly, Sept. 3-May 6 (77-1-311)
 (1) Radiology-Gastroenterology Correlative Conference; monthly, Sept.-May (77-1-312)
 (1) Radiobiology Conference; monthly, Sept. 24-May 27 (77-1-313)
 Contact: John J. Kenny, M.D., Chrm., Cont. Med. Educ., **Mercy/Pgh.**

Pittsburgh, North Hills Passavant Hosp., '76-'77 Academic Year

(1) Continuing Education for Physicians; by Pitt, monthly, Sept.-May (77-1-293)
 Contact: Herbert H. Anderson, M.D., North Hills Passavant Hosp., Pittsburgh 15237

Pittsburgh; Pitt, '76-'77 Academic Year

(1) Hematology Review; Sept. 13-17 (76-2-26)
 (1) Renal Function and the Actions of Humoral and Diuretic Agents; at Central Medical Pavilion; Sept. 13 (76-2-121)
 (1) Untoward Reactions of Drugs; at Central Medical Pavilion; Oct. 11 (76-2-122)
 (1) Office Neurological Examination; at Central Medical Pavilion; Nov. 8 (76-2-123)
 (1) Dermatologic Manifestations of Internal Disease; at Central Medical Pavilion; Dec. 13 (76-2-124)
 (1) Continuing Education in Otolaryngology; weekly, Sept.-May (77-1-261)
 (1) Seminars in Clinical Cardiology; monthly, Sept.-May (77-1-262)
 (1) WPIC Guest Lecture Series; at Western Psychiatric Inst. and Clinic; monthly (77-1-263)
 (1) Staunton Staff Case Conference; at Falk Clinic, Pittsburgh; weekly (77-1-264)
 (1) Dermato-Pathology Conference; at VA Hosp., Pittsburgh; weekly (77-1-265)
 (1) Dermatologic Mycology Conference; at Falk Clinic, Pittsburgh; weekly (77-1-266)
 (1) Dermatology Rounds; at Children's Hosp. of Pittsburgh; weekly (77-1-267)
 (1) Dermatology Rounds; at Presbyterian-Univ. Hosp., Pittsburgh; weekly (77-1-268)
 (1) Dermatology Clinical Case Presentation and Conference; at Falk Clinic, Pittsburgh; weekly (77-1-269)
 (1) Dermatology Conference; at Falk Clinic, Pittsburgh; weekly (77-1-270)
 (1) Dermato-Pathology Conference; weekly (77-1-271)
 (1) Dermatology Clinical Lecture Series; at Falk Clinic, Pittsburgh; weekly (77-1-272)
 (1) VAH Dermatology Rounds; at VA Hosp. (Oakland); weekly (77-1-273)
 (1) ENT Tumor Conference; at Presbyterian-Univ. Hosp., Pittsburgh; weekly (77-1-274)
 (1) Otolaryngology Tumor Conference; at Presbyterian-Univ. Hosp., Pittsburgh; weekly (77-1-275)

(1) Surgical Rounds; at Eye and Ear Hosp., Pittsburgh; weekly (77-1-276)
 (1) Otolaryngology Conference; at Eye and Ear Hosp., Pittsburgh; weekly (77-1-277)
 (1) Grand Rounds-Otolaryngology; at Eye and Ear Hosp., Pittsburgh; weekly (77-1-278)
 (1) Radiology Grand Rounds; weekly (77-1-279)
 (1) Teaching Conference-Radiology; four days a week (77-1-280)
 (1) Clinical Electronstomography; two days (77-1-281)
 (1) ICU Rounds-Children's; at Children's Hosp. of Pittsburgh; weekly (77-1-282)
 (1) Critical Care Medicine Conference; at Presbyterian-Univ. Hosp., Pittsburgh; weekly (77-1-283)
 (1) Anesthesiology Research Seminar; weekly (77-1-284)
 (1) Biochemical-Pathology Conference; weekly (77-1-285)
 (1) Pathology Teaching Conference; at Presbyterian-Univ. Hosp., Pittsburgh; weekly (77-1-286)
 (1) Anatomy and Cell Biology Seminar; weekly (77-1-287)
 (1) Rheumatology Grand Rounds; at Presbyterian-Univ. Hosp., Pittsburgh (77-1-288)
 (1) Rheumatology Seminar and Research Conference; weekly (77-1-289)
 (1) Rheumatology-Orthopedic Conference; weekly (77-1-290)
 (1) GI Journal Club; bi-monthly (77-1-291)
 (1) Anesthesiology-Critical Care Medicine Research Seminar; at Presbyterian-Univ. Hosp., Pittsburgh; weekly (77-1-292)
 (1) Anesthesiology Conference; at Magee-Womens Hosp., Pittsburgh; weekly (77-1-293)
 (1) Biomedical Seminars; bi-monthly (77-1-294)
 (1) Anesthesiology In-Service Meeting; at Presbyterian-Univ. Hosp., Pittsburgh; monthly (77-1-295)
 (1) Medical Pharmacology; weekly (77-1-296)
 (1) Clinical Pharmacology Concepts; at Presbyterian-Univ. Hosp., Pittsburgh; weekly (77-1-297)
 (1) Clinical Basic Science Conference; weekly (77-1-298)
 (1) Pediatric-Neurosurgery Conference; at Children's Hosp. of Pittsburgh; weekly (77-1-299)
 (1) Adult Orthopedic Grand Rounds; at VA Hosp. (Oakland); weekly (77-1-300)
 (1) Orthopedic-Radiology Conference; at Children's Hosp. of Pittsburgh; weekly (77-1-301)
 (1) Orthopedic Grand Rounds; at Children's Hosp. of Pittsburgh; weekly (77-1-302)
 (1) ENT Radiology Conference; at Eye and Ear Hosp. of Pittsburgh; weekly (77-1-303)
 (1) ENT Pathology Conference; at Eye and Ear Hosp. of Pittsburgh; weekly (77-1-304)
 (1) Otolaryngology Conference; weekly (77-1-305)
 (1) Glaucoma Conference; at Eye and Ear Hosp. of Pittsburgh; weekly (77-1-306)
 (1) External Eye Disease Conference; at Eye and Ear Hosp. of Pittsburgh; weekly (77-1-307)
 (1) Specialty Clinics in Ophthalmology; at Eye and Ear Hosp. of Pittsburgh; weekly (77-1-308)
 (1) Ophthalmic Pathology Conference; at Eye and Ear Hosp. of Pittsburgh; weekly (77-1-309)
 (1) Grand Rounds in Ophthalmology; at Eye and Ear Hosp. of Pittsburgh; weekly (77-1-310)
 (1) Journal Club-Ophthalmology; at Eye and Ear Hosp. of Pittsburgh; weekly (77-1-311)
 (1) Neural Science Conference-Neurology; at Children's Hosp. of Pittsburgh; weekly (77-1-312)
 (1) Neural Science Conference-Neurosurgery; at Children's Hosp. of Pittsburgh; weekly (77-1-313)
 (1) Neural Science Conference-Neuroradiology; at Children's Hosp. of Pittsburgh; weekly (77-1-314)
 (1) Neural Science Conference-Neuropathology; at Children's Hosp. of Pittsburgh; weekly (77-1-315)
 (1) Pediatric Radiology Conference; weekly (77-1-316)
 (1) Film Review-Radiology; at Children's Hosp. of Pittsburgh; five days per week (77-1-317)
 (1) Medical Review Rounds-Radiology; at Presbyterian-Univ. Hosp., Pittsburgh; five days per week (77-1-318)
 (1) Radiological-Surgical Conference; weekly (77-1-319)
 (1) Medical-Surgical Cardiovascular Conference; at Presbyterian-Univ. Hosp., Pittsburgh; weekly (77-1-320)
 (1) Radiological-Surgical Conference; weekly (77-1-321)
 (1) Surgical Seminar; weekly (77-1-322)
 (1) WPIC Educational Conference; at Western Psychiatric Inst. and Clinic, Pittsburgh; weekly (77-1-323)
 (1) Psychosomatic Conference; at Presbyterian-Univ. Hosp., Pittsburgh; weekly (77-1-324)
 (1) Medical Grand Rounds; weekly (77-1-325)
 (1) Ambulatory Care Conference; at Falk Clinic, Pittsburgh; two days per week (77-1-326)
 (1) Medical Specialty Conference; at Montefiore Hosp., Pittsburgh; three days per week (77-1-327)
 (1) Medical Grand Rounds; at Montefiore Hosp., Pittsburgh; weekly (77-1-328)
 (1) Infectious Disease Rounds; weekly (77-1-329)
 (1) Medical Surgical Conference; at Montefiore Hosp., Pittsburgh; weekly (77-1-330)
 (1) Renal-Water-Electrolyte Conference; at VA Hosp. (Oakland); weekly (77-1-331)
 (1) Renal-Hypertension Conference; at Presbyterian-Univ. Hosp., Pittsburgh; weekly (77-1-332)

(1) General Medical Conference; at VA Hosp. (Oakland); weekly (77-1-333)
 (1) Neurology-Neurosurgery Conference; at Children's Hosp. of Pittsburgh; weekly (77-1-334)
 (1) Clinical Conference-Neurology; weekly (77-1-335)
 (1) Neurology Basic Science Seminar; weekly (77-1-336)
 (1) Topics in Neurology; weekly (77-1-337)
 (1) Obstetrical Grand Rounds; at Magee-Womens Hosp., Pittsburgh; weekly (77-1-338)
 (1) Gynecology Grand Rounds; at Magee-Womens Hosp., Pittsburgh; weekly (77-1-339)
 (1) Neonatal Conference; at Magee-Womens Hosp., Pittsburgh; weekly (77-1-340)
 (1) Neonatal Grand Rounds; at Magee-Womens Hosp., Pittsburgh; weekly (77-1-341)
 (1) Pediatric Grand Rounds; at Children's Hosp. of Pittsburgh; weekly (77-1-342)
 (1) OPD Conference; at Children's Hosp. of Pittsburgh; two days per week (77-1-343)
 (1) Ambulatory Care Conference; at Children's Hosp. of Pittsburgh; weekly (77-1-344)
 (1) Pediatric Neurosurgery Conference; at Children's Hosp. of Pittsburgh; weekly (77-1-345)
 (1) Pediatric Radiology Conference; at Children's Hosp. of Pittsburgh; weekly (77-1-346)
 (1) Children's Hospital ICU Rounds; at Children's Hosp. of Pittsburgh; weekly (77-1-347)
 (1) Neuroanesthesiology Rounds; at Presbyterian-Univ. Hosp., Pittsburgh; weekly (77-1-348)
 (1) Medicine-Pathology Correlation Seminar; at Montefiore Hosp., Pittsburgh; weekly (77-1-349)
 (1) Neuroradiology Conference; at Children's Hosp. of Pittsburgh; weekly (77-1-350)
 (1) Film Review—Radiology; at Children's Hosp. of Pittsburgh; three days per week (77-1-351)
 (1) GI Review; at Presbyterian-Univ. Hosp., Pittsburgh; four days per week (77-1-352)
 (1) Vascular Review; at Presbyterian-Univ. Hosp., Pittsburgh; five days per week (77-1-353)
 (1) Neuroradiology Review; at Presbyterian-Univ. Hosp., Pittsburgh; five days per week (77-1-354)
 (1) Film Review—General; at Presbyterian-Univ. Hosp., Pittsburgh; five days per week (77-1-355)
 (1) Medical Review Rounds; at Presbyterian-Univ. Hosp., Pittsburgh; five days per week (77-1-356)
 (1) Seminar for Leaders in Group Process of Consultation; at Staunton Clinic, Pittsburgh; weekly (77-1-357)
 (1) Physiology Colloquium; weekly (77-1-358)
 (1) Pathology Seminar; weekly (77-1-359)
 (1) Trauma—Fracture Conference; at Children's Hosp. of Pittsburgh; weekly (77-1-360)
 (1) Clinical Pharmacology Seminar; at Presbyterian-Univ. Hosp., Pittsburgh; weekly (77-1-361)
 (1) Rheumatology Grand Rounds; at St. Margaret Mem. Hosp., Pittsburgh; monthly (77-1-362)
 (1) Clinical Endocrine Conference; weekly (77-1-363)
 (1) Hematology Conference; at Presbyterian-Univ. Hosp., Pittsburgh; weekly (77-1-364)
 (1) Cardiology Conference; at Montefiore Hosp., Pittsburgh; weekly (77-1-365)
 (1) Anatomy and Cell Biology Seminar; weekly (77-1-366)
 (1) Biochemical-Pathology Conference; at Presbyterian-Univ. Hosp., Pittsburgh; weekly (77-1-367)
 (1) Pathology Teaching Conference; at Presbyterian-Univ. Hosp., Pittsburgh; weekly (77-1-368)
 (1) Hematology Grand Rounds; weekly (77-1-369)
 (1) Hematology Journal Club; weekly (77-1-370)
 (1) Infectious Disease Conference; at Montefiore Hosp., Pittsburgh; weekly (77-1-371)
 (1) Medical Pharmacology Seminar; weekly (77-1-372)
 (1) Mortality Conference; weekly (77-1-373)
 (1) Urological Surgery Conference; at Presbyterian-Univ. Hosp., Pittsburgh; weekly (77-1-374)
 (1) Plastic Surgery Grand Rounds; at VA Hosp. (Oakland); weekly (77-1-375)
 (1) Plastic Surgery Teaching Conference; at Children's Hosp. of Pittsburgh; weekly (77-1-376)
 (1) Cardiac Arrhythmia and Electrophysiological Conference; at Presbyterian-Univ. Hosp., Pittsburgh; weekly (77-1-377)
 (1) Cardiology Grand Rounds; at Presbyterian-Univ. Hosp., Pittsburgh; weekly (77-1-378)
 (1) Rheumatology-Pathology Review; at St. Margaret Mem. Hosp., Pittsburgh; weekly (77-1-379)
 (1) Rheumatology-Radiology Review; at St. Margaret Mem. Hosp., Pittsburgh; weekly (77-1-380)
 (1) Rehabilitation Team in Action; at St. Margaret Mem. Hosp., Pittsburgh; weekly (77-1-381)
 (1) Arthritis and the Rehabilitation Team; at St. Margaret Mem. Hosp., Pittsburgh; weekly (77-1-382)
 (1) Orthopedic-Pathology Basic Science Conference; at Children's Hosp. of Pittsburgh; weekly (77-1-383)
 (1) Orthopedic Conference Combined St. Francis and Mercy Hosp.; weekly (77-1-384)

(1) Rheumatology for the Orthopedic Surgeon; at St. Margaret Mem. Hosp., Pittsburgh; weekly (77-1-385)
 (1) Orthopedic Grand Rounds; at Children's Hosp. of Pittsburgh; weekly (77-1-386)
 (1) Hand Surgery Grand Rounds; at VA Hosp. (Oakland); weekly (77-1-387)
 (1) Chest Surgery Conference; at VA Hosp. (Oakland); weekly (77-1-388)
 (1) Surgical Grand Rounds; weekly (77-1-389)
 (1) Medical Surgical Conference; at Montefiore Hosp., Pittsburgh; weekly (77-1-390)
 (1) Microneurosurgery of the Cranial Nerves; at Presbyterian-Univ. Hosp.; Sept. 8-11 (76-2-82)
 (1) Family Medicine Refresher Course; at Pittsburgh Hilton Hotel; Sept. 16-19 (76-2-83)
 (1) Seminars for the Practicing Physician; Thursdays, Sept. 16-April (77-1-334)
 (1) Eye Enucleation Course for Funeral Directors; Scaife Hall and Eye and Ear Hosp.; Sept. 18-19 and Nov. 20-21 (76-2-84)
 (1) Hypertension in Children and Adolescence; at Pittsburgh Hilton Hotel; Sept. 23-24 (76-2-85)
 (1) 20th Annual Series of Seminars in Patient Care; at Staunton Clinic, Pittsburgh; Wednesdays (76-2-86)
 (1) Case Centered Seminars in Psychotherapy; weekly; time and location to be announced (76-2-87)
 (1) Seminar for Leaders in Group Process of Consultation; Thursdays; at Staunton Clinic, Pittsburgh (76-2-88)
 (1) Seminars in Clinical Cardiology; monthly, Sept.-May (77-1-335)
 (1) Continuing Education in Otolaryngology; Sept.-May (77-1-336)
 (1) Diabetes Symposium; Univ. Health Center of Pittsburgh; fall 1976 (76-2-89)
 (1) Chemotherapy of Metastatic Cancer; at Univ. Health Center of Pittsburgh; Oct. 1 (76-2-90)
 (1) Hematology Review; at William Penn Hotel; Oct. 6-9 (76-2-91)
 (1) Cardiopulmonary Resuscitation Course; Oct. 22-23 (76-2-92)
 (1) The Third OB-GYN Anesthesia Symposium; at Grad. School of Public Health; Oct. 23 (76-2-93)
 (1) Seventh Workshop in Use of Staplers in Surgery; at Univ. Health Center of Pittsburgh; Nov. 8-9 (76-2-94)
 (1) Bi-State Meeting—American College of Physicians; at Montefiore Hosp.; Nov. 12-13 (77-2-95)
 (1) Head and Neck Cancer; at Univ. Health Center of Pittsburgh; Nov. 17-18 (76-2-96)
 (1) Seminar and Workshop in Diagnostic and Operative Laparoscopy; at Magee-Womens Hosp.; Nov. (76-2-97)
 (1) Surgical Anatomy and Techniques of the Temporal Bone; at Eye and Ear Hosp.; Nov. (76-2-98)
 (1) Workshop in Neuroanesthesia; at Presbyterian-University Hosp.; Dec. 1-3 (76-2-99)
 (1) Phaco-Emulsification: Surgical Techniques; at Eye and Ear Hosp.; Dec. 2-4 (76-2-100)
 (1) Diseases Due to Immune Mechanisms; at Breakers Hotel, Palm Beach, Florida; Dec. 9-13 (76-2-101)
 (1) Phaco-Emulsification: Surgical Techniques; at Eye and Ear Hosp.; Jan. 17-19 (77-1-337)
 (1) Cardiopulmonary Resuscitation Course; Mar. 11-12 (77-1-341)
 (1) American Urological Association Meeting; at Pittsburgh Hilton Hotel; Mar. 18-20 (77-1-342)
 (1) Clinical Immunopathology; at William Penn Hotel; Mar. 27-30 (77-1-343)
 (1) Seminar and Workshop in Diagnostic and Operative Laparoscopy; at Magee-Womens Hosp.; March (77-1-344)
 (1) Selected Seminars in Nutrition; at Univ. Health Center of Pittsburgh; Tuesdays, Apr. 5-June 7 (77-1-345)
 (1) Fourth Annual Symposium for Nurse Anesthetists; at Pittsburgh Hilton Hotel; Apr. 22-24 (77-1-346)
 (1) Cardiopulmonary Resuscitation Course; Apr. 29-30 (77-1-347)
 (1) Internal Medicine Board Review Course; at Univ. Health Center of Pittsburgh; April-May (77-1-348)
 (1) Sixth Sports Medicine Symposium; at Univ. Health Center of Pittsburgh; April (77-1-349)
 (1) Phaco-Emulsification: Surgical Techniques; at Eye and Ear Hosp.; May 2-4 (77-1-350)
 (1) Selected Subjects in Internal Medicine; at William Penn Hotel; May 16-20 (77-1-351)
 (1) Ophthalmic Microsurgery; at Eye and Ear Hosp.; May (77-1-352)
 (1) Eleventh Annual Symposium on Emergency and Critical Care Medicine; May (77-1-353)
 (1) Nuclear Medicine Update; May (77-1-354)
 (1) 1st International Facial Nerve Symposium in the USA; at Pittsburgh Hilton Hotel; June 19-23 (77-1-355)
 (1) Contemporary Problems in Surgery; at Montefiore Hosp.; June (77-1-356)
 (1) Pediatric Otolaryngology; at Univ. Health Center of Pittsburgh; June (77-1-357)
 Contact: William M. Cooper, M.D., Assoc. Dean for Cont. Med. Educ., Pitt
 Pittsburgh; St. Francis; Sept. 16-17, 1976
 (1) Seminar in Pulmonary Physiology and Medicine (76-2-73)
 Contact: Sukhdev S. Grover, M.D., Dir. of Pulm. Disease Div., St. Francis
 Pittsburgh; Shadyside Hosp.; '76-'77 Academic Year
 (1) Surgical Grand Rounds; by Pitt; Mondays (77-2-3)
 (1) Radiology Conference; by Pitt; Tuesdays (77-2-4)

(1) Pathology Conference; by **Pitt**; Thursdays (77-2-5)
(1) Medical Grand Rounds; by **Pitt**; Thursdays (77-2-6)
Contact: Karl H. Franz, M.D., DME, Shadyside Hosp., 5230 Centre Ave., Pittsburgh, 15232

Pittsburgh; Alternating Between St. Johns Gen. Hosp. and Suburban Gen. Hosp.; '76-'77 Academic Year

(1) Continuing Education for Physicians; by **Pitt**; monthly, Sept. 15-June 15 (77-1-294)

Contact: Thomas Graham, M.D., Suburban Gen. Hosp., Pittsburgh 15202 or Raymond Wojciak, D.O., St. Johns Gen. Hosp., Pittsburgh 15212

Pittsburgh; **St. Margaret**; '76-'77 Academic Year

(1) Workshop in Rheumatology and Orthopedics (Surgical Indications); 6 days a month for 12 months; Sept. 1-August 31 (77-1-41)

(1) A One Day Symposium on Rheumatic Diseases; date and location to be announced; one day-November (77-2-7)

(1) Subspecialty Conferences; monthly, Sept. 1-August 31 (Fridays) (77-1-42)
(1) Seminars for the Family Physician; three half-days, tentatively Oct. 21, 1976; Jan. 20, 1977, Apr. 21, 1977 (77-1-43)

(1) Selected Topics in Rheumatology; weekly, Sept. 1-Aug. 31 (77-1-44)

(1) Rheumatology-Radiology Review; weekly, Sept. 1-Aug. 31 (77-1-45)

(1) Rheumatology-Pathology Review; weekly, Sept. 1-Aug. 31 (77-1-46)

(1) Rheumatology for the Orthopedic Surgeon; weekly, Sept. 1-Aug. 31 (77-1-47)

(1) Rheumatology Grand Rounds; monthly, Sept. 1-Aug. 31 (77-1-48)

(1) Rehabilitation Team in Action; weekly, Sept. 1-Aug. 31 (77-1-49)

(1) Radiology Conferences; every other Friday, Sept. 1-Aug. 31 (77-1-50)

(1) Psychiatry Seminars in Family Practice; every Thursday, Sept. 1-Aug. 31 (77-1-51)

(1) Pediatric Conference; every other Tuesday, Sept. 1-Aug. 31 (77-1-52)

(1) OB-GYN Conferences; every other Tuesday, Sept. 1-Aug. 31 (77-1-53)

(1) Neurology Conferences; 2nd and 4th Fridays of each month, Sept. 1-Aug. 31 (77-1-54)

(1) Family Practice Medical Conferences; every Saturday except last of month, Sept. 1-Aug. 31 (77-2-8)

(1) Continuing Medical Education Postgraduate Lectures; every Thursday, Sept. 1-Aug. 31 (77-1-55)

(1) Community and Family Practice Seminars; every other Monday, Sept. 1-Aug. 31 (77-1-56)

(1) Cardiology Conferences; every other Friday, Sept. 1-Aug. 31 (77-1-57)

(1) Arthritis and the Rehabilitation Team; weekly, Sept. 1-Aug. 31 (77-1-58)

Contact: Paul W. Dishart, M.D., Coord. Dir., CME, **St. Margaret**

Pittsburgh; **West Penn**; '76-'77 Academic Year

(1) Surgical Complications; 2nd Monday of each month (76-2-80)

(1) Pathology-Plastic Surgery Conference; every Tuesday (76-2-81)

(1) Gross Autopsy Conference; every Wednesday and Friday (76-2-82)

(1) Microscopic Slide Seminar; every Tuesday (76-2-83)

(1) Kodachrome Conference; every Tuesday (76-2-84)

(1) Clinical Cardiology Conference; every Friday (76-2-85)

(1) Electrocardiography Conference; 1st and 3rd Wednesday of each month (76-2-86)

(1) Radiology Physics; every Friday (76-2-87)

(1) Surgical Journal Club; 3rd Thursday of each month (76-2-88)

(1) Neuroradiology Conference; every Tuesday (76-2-89)

(1) Pediatric Visiting Professor Rounds; every Tuesday (76-2-90)

(1) Pediatric Conference; every Monday, Wednesday and Friday (76-2-91)

(1) Pediatric Psychiatry Conference; as announced (76-2-92)

(1) Urology Conference; every Monday (76-2-93)

(1) Oncology Conference; 1st Friday of each month (76-2-94)

(1) Fracture Trauma and Neurosurgery Conference; 1st Tuesday of each month (76-2-95)

(1) Plastic Surgery Grand Rounds; every Friday (76-2-96)

(1) Radiology Conference; 2nd Tuesday of each month (76-2-97)

(1) Head and Neck Tumor Conference; every Friday (76-2-98)

(1) Hand Conference; every Friday (76-2-99)

(1) General Plastic Surgery Lecture; every Wednesday (76-2-100)

(1) Cleft Palate Clinic; 2nd Monday of each month (76-2-101)

(1) Dermatology Clinical Teaching Conference; every Tuesday (76-2-102)

(1) Anesthesia Conference; every Tuesday (76-2-103)

(1) Medical Grand Rounds; 1st, 2nd, 3rd, and 5th Thursdays of each month (76-2-104)

(1) Medical Mortality Conference; 4th Thursday of each month (76-2-105)

(1) OB-GYN Division Meeting; every Friday (76-2-106)

(1) Rheumatology Conference; 3rd Monday of each month (76-2-107)

(1) Dermatology Conference; 2nd, 4th Tuesday of each month (76-2-108)

(1) Hematology-Oncology Conference; 2nd, 4th Wednesday of each month (76-2-109)

(1) Pulmonary Conference; 1st, 3rd, 5th Tuesday of each month (76-2-110)

(1) Surgical Grand Rounds; 2nd, 3rd, 5th Friday of each month (76-2-111)

(1) Surgery-Radiology-Pathology Conference; 4th Tuesday of each month (76-2-112)

(1) Chest and Vascular Conference; 2nd, 4th Thursday of each month (76-2-113)

(1) Surgical Mortality Conference; 4th Friday of each month (76-2-114)

(1) Metabolic/Endocrine/Renal Conference; 2nd, 4th Monday of each month (76-2-115)

(1) Gastroenterology Conference; 1st Monday of each month (76-2-116)

(1) Cardiology 1977, Feb. 27-March 6 (77-1-25)

(1) Surgical Visiting Professor, as announced (76-2-118)

(1) Surgical Conference; 1st Monday of each month (76-2-119)

(1) Head and Neck Tumor Conference Series; Feb. 4-Mar. 25; at Mellon Pavilion, Pittsburgh (77-1-358)

Contact: Robert M. Grom, Med. Educ. Coord., **West Penn**

Pottsville; Good Samaritan Hosp.; '76-'77 Academic Year

(1) Continuing Medical Education Seminars; by **U. of Pa.**; monthly, Oct. 28-May 26 (77-1-40)

Contact: Norman Wall, M.D., Good Samaritan Hosp., Norwegian and Tremont Sts., Pottsville 17901

Pottsville; Pottsville Hosp.; '76-'77 Academic Year

(1) Postgraduate Seminars for Physicians; by **Jefferson**; monthly, Sept. 2-first Thurs. each month for 10 months (77-1-1)

Contact: Edward W. Cubler, M.D., DME, Pottsville Hosp. and Warne Clinic, Mauch Chunk and Jackson Sts., Pottsville 17901

Reading; Berks Co. Med. Soc.; '76-'77 Academic Year

(1) Continuing Medical Education Program; by **Reading**; weekly, Sept.-June (77-1-2)

Contact: Leonard M. DeVecchio, M.D., 308 Old Airport Rd., Douglassville 19518

Roaring Spring; Nason Hosp.; '76-'77 Academic Year

(1) Continuing Education for Physicians; by **Pitt**; monthly, Sept.-June (77-1-292)

Contact: Marion Morelli, M.D., Chm. Educ. Cmte., Nason Hosp., Roaring Spring 16673

Rochester; Beaver Co. Med. Soc.; '76-'77 Academic Year

(1) Continuing Education for Physicians; by **Pitt**; monthly, Sept.-May (77-1-283)

Contact: Mrs. Susan Frey, 350 Adams St., Rochester 15074

Sayre; **Packer**; 1976

(1) Mammography, Angiography, Tomography for Radiologists (76-2-29)

(1) Endotracheal Intubation (76-2-28)

(1) Anesthesiology in Cardiac Patients (76-2-27)

Contact: Paul C. Royce, M.D., Ph.D., DME, **Packer**

Sellersville; Penn Found. for Mental Health; '76-'77 Academic Year

(1) Continuing Medical Education Seminar Series; by Grand View Hosp. and **Temple**; monthly, Sept. 28-May 31 (77-1-117)

(1) Interface of Medicine and Psychiatry; by **Temple**; Oct. 21 (76-2-48)

Contact: Norman L. Loux, M.D., Med. Dir., Penn Foundation for Mental Health, Inc., Box 32, Lawn Ave., Sellersville 18960

Sharon; Mercer Co. Med. Soc. and Sharon Gen. Hosp.; '76-'77 Academic Year

(1) Continuing Education for Physicians; by **Pitt**; bimonthly, Oct.-Mar. (77-1-290)

Contact: Thomas V. Murray, M.D., Dir. Cont. Med. Educ., Sharon Gen. Hosp., Sharon 16147

Sharon; Tumor Clinic of Sharon Gen. Hosp.; '76-'77 Academic Year

(1) Continuing Education for Physicians; by **Pitt**; monthly, Oct.-May (77-1-291)

Contact: Thomas V. Murray, M.D., Dir. Cont. Ed., Sharon Gen. Hosp., Sharon 16147

St. Marys; Elk-Cameron Co. Med. Soc.; 1976

(1) Continuing Education for Physicians; by **Pitt**; weekly, Sept. 15-Nov. 17 (76-2-75)

Contact: Bernard L. Coppola, M.D., Pgm. Chm., Elk-Cameron Co. Med. Soc., Kaul Mem. Hosp., St. Marys 15857

Sunbury; Sunbury Community Hosp.; '76-'77 Academic Year

(1) Postgraduate Medical Seminars; by **Hahneemann**; 2nd and 4th Wednesdays, Sept., Oct., Nov., Feb., March, and Apr. (77-1-5)

Contact: Willard W. Christman, M.D., DME, Sunbury Community Hosp., Sunbury 17801

Uniontown; Fayette Co. Med. Soc.; '76-'77 Academic Year

(1) Continuing Education for Physicians; by **Pitt**; monthly, Sept.-June (77-1-292)

Contact: Walter Lion, Exec. Sec., Fayette Co. Med. Soc., Uniontown 15401

Warren; **Warren State**; '76-'77 Academic Year

(1) Guest Lecturer Program; monthly, Friday and Saturday (77-1-325)

(1) Literature Seminar; Thursdays (77-1-326)

(1) Psychiatric and Medical Film Seminar, Mondays (77-1-327)

Contact: Leonard H. Brennan, M.D., Dir. of Med. Educ., **Warren State**

Wilkes-Barre; Luzerne County Med. Soc.; '76-'77 Academic Year

(1) Continuing Medical Education for Physicians; by **Jefferson**; monthly (except summer), Jan. 1976-Jan. 1977 (76-2-34)

Contact: Richard Alley, M.D., Luzerne County Med. Soc., 130 S. Franklin St., Wilkes-Barre 18701

Williamsport; Williamsport Hosp.; '76-'77 Academic Year

(1) Continuing Medical Education Seminars; by **U. of Pa.**; weekly, Sept. 6-June 25 (77-1-38)

Contact: Herman W. Rannels, M.D., Williamsport Hosp., 777 Rural Ave., Williamsport 17701

CALENDAR

A quick reference to Category I continuing medical education opportunities in Pennsylvania by date.

SEPTEMBER

- 2 Breast Cancer Network; at Jeanes Hosp. (76-2-136)
- 8 Nutrition; at Allentown-Sacred Heart Hosps. (77-1-39)
- 8-11 Microneurosurgery of the Cranial Nerves; at Presbyterian-University Hosp. (76-2-82)
- 9 Acute and Chronic Liver Disease; at Nesbitt Mem. Hosp., Kingston (76-2-69)
- 10 Acid Base Problems; at Williamsport Hosp. (77-1-38)
- 13 Renal Function and the Actions of Humoral and Diuretic Agents; at Central Medical Pavilion, Pittsburgh (76-2-121)
- 13-15 Advances in Diagnosis and Treatment of Neurological Disease; by Hahnemann, Phila. (76-2-50)
- 13-17 Hematology Review; at Pitt (76-2-26)
- 14 Drug Therapy for the Geriatric Patient; at Mayview State Hosp., Bridgeville (76-2-125)
- 14 History of Psychiatry and Psychotherapy; at Woodville St. Hosp., Carnegie (77-1-35)
- 15 Neonatal Problems; at Hanover Gen. Hosp. (76-2-78)
- 15 2nd Annual Arthritis Seminar; at Geisinger, Danville (76-2-56)
- 16 Calcium Metabolism; at Hazleton St. Gen. Hosp. (77-1-37)
- 16-17 Seminar in Pulmonary Physiology and Medicine; at St. Francis Gen. Hosp., Pittsburgh (76-2-73)
- 16-19 Advances in Dermatology, 1976; at Univ. of Pa. Hosp. (76-2-69)
- 16-19 Family Medicine Refresher Course; at Pittsburgh Hilton Hotel (76-2-83)
- 17 Perinatology; at Williamsport Hosp. (77-1-38)
- 17 Scientific Session, Colon & Rectal Surgery; at Union League of Phila. (76-2-71)
- 18-19 Eye Enucleation Course for Funeral Directors; at Scaife Hall and Eye and Ear Hosp. (76-2-84)
- 21 Classical Psychoanalysis; Cultural and Interpersonal Psychoanalytic Theories; at Woodville St. Hosp., Carnegie (77-1-35)
- 22 Advances in Management of Cancer; at Allentown-Sacred Heart Hosps. (77-1-39)
- 23 Treatment with Drugs of Anxiety, Depression, Schizophrenia; at Hazleton St. Gen. Hosp. (77-1-37)
- 23-24 Hypertension in Children and Adolescence; at Pittsburgh Hilton Hotel (76-2-85)
- 24 Cardiac-Vascular; at Williamsport Hosp. (77-1-38)
- 24-25 Retrieval, Management and Comprehensive Care of the Patient with Chronic Obstructive Airway Disease; at Sheraton Inn, Danville (76-2-57)
- 26-30 2nd International Symposium on Planning of Radiological Depts.; at Benjamin Franklin Hotel, Phila. (76-2-140)
- 27-Oct. 1 Endocrinology; at Conemaugh, Johnstown (76-2-29)
- 28 Cardiac Arrhythmias; at J. C. Blair Hosp., Huntingdon (76-2-64)
- 28 Other Psychoanalytic and Psychodynamic Theories; at Woodville St. Hosp., Carnegie (77-1-35)
- 29 Office Gynecology; at Geisinger, Danville (76-2-63)
- 30 Antibiotic Therapy of Infection; at Annie Warner Hosp., Gettysburg (76-2-68)
- 30 Epilepsy; at Hazleton St. Gen. Hosp. (77-1-37)
- 30 The Long-Lived; at EPPI (76-2-35)

OCTOBER

- 1 Chemotherapy of Metastatic Cancer; at Univ. Health Center of Pittsburgh (76-2-90)
- 1 Urinary Tract Infections; at Williamsport Hosp. (77-1-38)
- 2 Breast Cancer Network; at Jeanes Hosp. (76-2-136)
- 5 The Psychiatric Examination and Clinical Manifestations of Psychiatric Disorders; at Woodville St. Hosp., Carnegie (77-1-35)
- 6 Acute Stress Reactions: Crisis for Patient and Physician; at Geisinger, Danville (76-2-58)
- 6-9 Hematology Review; at William Penn Hotel (76-2-91)
- 7 Newer Developments in Obstetrics; at Hazleton St. Gen. Hosp. (77-1-37)
- 7-9 Pediatric Dermatology; at Benjamin Franklin Hotel, Phila. (76-2-141)
- 7-10 3rd Annual Temple Conference on Behavior Therapy and Behavior Modification; at the Hilton Hotel, Phila. (76-2-142)
- 8 Small Bowel and Inflammatory Bowel Disease; at Williamsport Hosp. (77-1-38)

- 10-13 Clinical Skills for Physician Assistants IV; by Hahnemann, Phila. (76-2-51)
- 11 Untoward Reactions of Drugs; at Central Medical Pavilion, Pittsburgh (76-2-122)
- 11-13 ECG Core Curriculum; at Holiday Inn of Phila. (76-2-72)
- 11-22 Workshops in Respiratory Intensive Care; by Hahnemann, Phila. (76-2-52)
- 12 Leukemia; at Mayview State Hosp., Bridgeville (76-2-126)
- 12 Schizophrenia; at Woodville St. Hosp., Carnegie (77-1-35)
- 14 Late Developments in Ca. Therapy; at Hazleton St. Gen. Hosp. (77-1-37)
- 14 Medical Management of Acute Renal Failure; at Nesbitt Mem. Hosp., Kingston (76-2-70)
- 14 Medical or Psychiatric Problem? Exercises in Differential Diagnosis; at EPPI (76-2-34)
- 14 Pediatric Allergies and Skin Infections of Childhood; at Hanover Gen. Hosp. (76-2-79)
- 15 Infertility (work-up); at Williamsport Hosp. (77-1-38)
- 17-28 Course in Bronchoesophagology; at Chevalier Jackson Clinic, Phila. (77-1-4)
- 19 Schizophrenia; at Woodville St. Hosp., Carnegie (77-1-35)
- 20 Controversy in Contraceptives; at Allentown-Sacred Heart Hosps. (77-1-39)
- 20 Emergency Medicine Seminar; at Geisinger, Danville (76-2-59)
- 21 Arthritis Day; at Conemaugh, Johnstown (76-2-30)
- 21 Dx. Rx of Acute Abdominal Injuries; at Hazleton St. Gen. Hosp. (77-1-37)
- 21 Interface of Medicine and Psychiatry; at Penn Found. for Mental Health, Inc., Sellersville (77-1-118)
- 21 Medical or Psychiatric Problem? Exercises in Differential Diagnosis; at EPPI (76-2-34)
- 21 Seminars for the Family Physician; at St. Margaret Mem. Hosp., Pittsburgh (77-1-43)
- 22 Carcinoma; at Williamsport Hosp. (77-1-38)
- 22-23 Cardiopulmonary Resuscitation Course; Oct. 22-23 (76-2-92)
- 23 The Third OB-GYN Anesthesia Symposium; at Graduate School of Public Health (76-2-93)
- 25-27 Electrocardiography for the Practitioner; by Hahnemann, Phila. (76-2-53)
- 26 Cancer Chemotherapy; at J. C. Blair Hosp., Huntingdon (76-2-65)
- 26 Paranoid Reactions; at Woodville St. Hosp., Carnegie (77-1-35)
- 26-27 Hypertension; at Conemaugh, Johnstown (76-2-31)
- 28 Evaluation of Pulmonary Function; at Hazleton St. Gen. Hosp. (77-1-37)
- 28 Management of Comatose Patient; at Good Samaritan Hosp., Pottsville (77-1-40)

Upcoming PMS Meetings

October 31, 1976—Holiday Inn, City Line, Philadelphia—"Doctor-Patient Relations."

November 3-5, 1976—Hershey Motor Lodge and Convention Center, Hershey—Medical Arts '76, including scientific sessions by: Pennsylvania Society of Colon and Rectal Surgery; Pennsylvania Chapter, American College of Emergency Physicians; Pennsylvania Orthopaedic Society; American Association of Medical Assistants, Inc., Pennsylvania Society; Central Pennsylvania Chapter, American College of Surgeons; Robert H. Ivy Society and the Pennsylvania Council of Health Professionals; and a half-day session by Pennsylvania Medical Society on "Laser Holography and Its Applications to Medical Science."

Seminars for Residents:

November 15-16, 1976—Stockyard Inn, Lancaster.

November 17-18, 1976—Penn Harris Motor Inn, Camp Hill.

January 11-12, 1977—Allegheny County Medical Society, Pittsburgh.

January 13-14, 1977—Philadelphia County Medical Society, Philadelphia.

(76-1-XX) Numbers in parentheses at the end of the item are code numbers which will be helpful as a reference to find a contact for more information.

See: town, institution, and code numbered item in Announcements section for complete details.

- 28 Management of Hypertension; at Annie Warner Hosp., Gettysburg (76-2-68)
- 28 Medical or Psychiatric Problem? Exercises in Differential Diagnosis, at EPPI (76-2-34)
- 28-30 Pediatric Endoscopy; by Hahnnemann, Phila. (76-2-54)
- 29 Problems of the Aging; at Williamsport Hosp. (77-1-38)
- 30 2nd Annual Weiss-English Psychosomatic Symposium; by Temple (76-2-144)
- 30-31 Issues and Answers in Medical Practice; at Sheraton Inn, Danville (76-2-60)

NOVEMBER

- 3 Current Problems in Neurology; at Geisinger, Danville (76-2-61)
- 4 Medical or Psychiatric Problem? Exercises in Differential Diagnosis, at EPPI (76-2-34)
- 4 Organization of the Emergency Room—Equipment, Personnel, Procedures—Handling of Medical Disasters; at Hazleton St. Gen. Hosp. (77-1-37)
- 5 High Risk Newborns; at Williamsport Hosp. (77-1-38)
- 6 Primary Management of Radiation Injuries (76-2-79)
- 8 Office Neurological Examination; at Central Medical Pavilion, Pittsburgh (76-2-123)
- 8-9 Seventh Workshop in the Use of Staplers in Surgery; at Univ. Health Center of Pittsburgh (76-2-94)
- 8-9 Spectrum of Hypertensive Drugs; by Hahnnemann, Phila. (76-2-55)
- 9 Affective Reactions; at Woodville St. Hosp., Carnegie (77-1-35)
- 9 Diarrhea; at Mayview State Hosp., Bridgeville (76-2-127)
- 10 Estrogen Therapy; at Allentown-Sacred Heart Hosps. (77-1-39)
- 11 Medical or Psychiatric Problem? Exercises in Differential Diagnosis, at EPPI (76-2-34)
- 11 Office Dermatology; at Nesbitt Mem. Hosp., Kingston (76-2-71)
- 11 Symposium on Liver Diseases; at Hazleton St. Gen. Hosp. (77-1-37)
- 11 The Emotional and Hyperactive Child and Teenager; at Hanover Gen. Hosp. (76-2-80)
- 12 Sodium and Water Balance Problems; at Williamsport Hosp. (77-1-38)
- 12-13 Bi-State Meeting—American College of Physicians; at Montefiore Hosp. (76-2-95)
- 13 What's New in Bronchial Asthma; at Holiday Inn East, Bethlehem (76-2-68)
- 16 Acute and Chronic Brain Syndromes; at Woodville St. Hosp., Carnegie (77-1-35)
- 16-17 Update on Psychotherapeutics for the Primary Care Physician; at Conemaugh, Johnstown (76-2-32)
- 17 Recent Advances in Pediatrics; at Geisinger, Danville (76-2-62)
- 17 17th Annual Forman Course—Current Problems in Perinatology; by Temple (76-2-145)
- 17 Symposium: Management of the Acute Critically Ill Patient; at Jeanes Hosp. (76-2-139)
- 17-18 Head and Neck Cancer; at Univ. Health Center of Pittsburgh (76-2-96)
- 18 Liver Diseases; at Hazleton St. Gen. Hosp. (77-1-37)
- 18 Medical or Psychiatric Problem? Exercises in Differential Diagnosis, at EPPI (76-2-34)
- 18 Modern Management of Coronary Artery Disease; at Good Samaritan Hosp., Pottsville (77-1-40)
- 19 Pathology at Williamsport Hosp. (77-1-38)
- 19-20 Surgical Symposium—Clinical Concepts of Breast Disease; by Temple (76-2-146)
- 23 Acute and Chronic Brain Syndromes; at Woodville St. Hosp., Carnegie (77-1-35)
- 23 Emergency Medicine; at J. C. Blair Hosp., Huntingdon (76-2-66)
- 29-Dec. 1 The Current Techniques of Operative Neurosurgery; by Hahnnemann, Phila. (76-2-49)
- 30 Epilepsy and Mental Retardation; at Woodville St. Hosp., Carnegie (77-1-35)

DECEMBER

- 1-3 Workshop in Neuroanesthesia; at Presbyterian-Univ. Hosp. (76-2-99)
- 2 Missed Fractures and Injuries on Basis of X-Rays; at Hazleton St. Gen. Hosp. (77-1-37)
- 2-4 Phaco-Emulsification. Surgical Techniques; at Eye and Ear Hosp. (76-2-100)
- 3 Emergency Pediatrics Care; at Williamsport Hosp. (77-1-38)
- 3-4 Minimal Brain Dysfunction in Children; at Marriott Motor Inn, Bala Cynwyd (76-2-147)
- 7 Anxiety and Conversion Reactions; at Woodville St. Hosp., Carnegie (77-1-35)
- 8 Learning Disabilities; at Allentown-Sacred Heart Hosps. (77-1-39)

- 9 Depression; at EPPI (76-2-33)
- 9 Emergency Medicine. Poisoning, Drowning, Acute GI Bleeding, Head Trauma, Acute Trauma—Chest, Abdomen, Fractures; at Hazleton St. Gen. Hosp. (77-1-37)
- 9-13 Diseases Due to Immune Mechanisms; at Breakers Hotel, Palm Beach, Florida (76-2-101)
- 10 Diabetes; at Williamsport Hosp. (77-1-38)
- 13 Dermatologic Manifestations of Internal Disease; at Central Medical Pavilion, Pittsburgh (76-2-124)
- 13-17 Introductory Diagnostic Ultrasound; at Episcopal Hosp., Phila. (77-1-105)
- 14 Dissociative Reaction and Phobic Reaction; at Woodville St. Hosp., Carnegie (77-1-3)
- 14 Menstrual Irregularities and Contraception; at J. C. Blair Hosp., Huntingdon (76-2-67)
- 14 Stasis Ulcer; at Mayview State Hosp., Bridgeville (76-2-128)
- 15 Learning Disabilities and Dyslexia; at Hanover Gen. Hosp. (76-2-81)
- 16 Growth Disturbance in Children; at Hazleton St. Gen. Hosp. (77-1-37)
- 17 Office Gynecology; at Williamsport Hosp. (77-1-38)
- 21 Obsessive-Compulsive Reaction and Neurotic Depressive Reactions; at Woodville St. Hosp., Carnegie (77-1-35)
- 23 Ulcerative Colitis; at Good Samaritan Hosp., Pottsville (77-1-40)
- 26-Jan. 2 Clinical Gastroenterology; at Hotel Rose Hall Inter-Continental, Montego Bay, Jamaica (77-1-120)
- 28 Personality Disorders; at Woodville St. Hosp., Carnegie (77-1-35)

JANUARY

- 4 Sexual Deviations; at Woodville St. Hosp., Carnegie (77-1-35)
- 6 Renal Disease Symposium: Medical Management of Renal Disease, Antihypertensive Rx., Renin and Blood Pressure Disorder; at Hazleton St. Gen. Hosp. (77-1-37)
- 7 Childhood Malignancy—Leukemia and Wilm's Tumor; at Williamsport Hosp. (77-1-38)
- 10-14 Diagnostic Ultrasound—Advanced Abdominal Scanning; at Episcopal Hosp., Phila. (77-1-106)
- 11 Alcoholism; at Woodville St. Hosp., Carnegie (77-1-35)
- 12 Pediatric Pharmacology; at Allentown-Sacred Heart Hosps. (77-1-39)
- 13 New Concepts—Management of Multiple Sclerosis; at Nesbitt Mem. Hosp., Kingston (77-1-284)
- 13 Parkinson's Disease—Office Management; at Nesbitt Mem. Hosp., Kingston (77-1-284)
- 13 Schizophrenia; at EPPI (77-1-80)
- 13 The Anemias; Primary, Secondary and Genetic; at Hanover Gen. Hosp. (77-1-328)
- 14 Antibiotics; at Williamsport Hosp. (77-1-38)
- 17 Medical and Psychiatry Continuing Education; at Allentown St. Hosp. (77-1-177)
- 17-19 Phaco-Emulsification: Surgical Techniques; at Eye and Ear Hosp. (77-1-337)
- 18 Addictions; at Woodville St. Hosp., Carnegie (77-1-35)
- 20 Seminars for the Family Physician; at St. Margaret Mem. Hosp., Pittsburgh (77-1-43)
- 20-21 The Practice of Behavior Therapy with Children: A Training Seminar; at the Hilton Hotel, Phila. (77-1-121)
- 21 Oncology; at Williamsport Hosp. (77-1-38)
- 21-22 Cardiopulmonary Resuscitation Course (77-1-338)
- 22-23 Workshop in Surgery of the Posterior Fossa; at Sheraton Airport Inn, Phila. (77-1-122)
- 25 Psychosomatic Medicine; at Woodville St. Hosp., Carnegie (77-1-35)
- 26 Abdominal Pain in Children; at Allentown-Sacred Heart Hosps. (77-1-39)
- 27 Juvenile Diabetes; at Good Samaritan Hosp., Pottsville (77-1-40)

FEBRUARY

- 1 Psychiatric Emergencies; at Woodville St. Hosp., Carnegie (77-1-35)
- 4 Learning Disabilities; at Williamsport Hosp. (77-1-38)
- 7-18 Chevalier Jackson Basic Course in Bronchoesophagology; by Temple (77-1-176)
- 8 Unusual Psychiatric Disorders, Postpartum Disorders; at Woodville St. Hosp., Carnegie (77-1-35)
- 9 Handicapped Child; at Allentown-Sacred Heart Hosps. (77-1-39)
- 10 Manic-Depressive Illness; at EPPI (77-1-81)
- 10 New Aspects of Management and Treatment of Endometriosis; at Nesbitt Mem. Hosp., Kingston (77-1-285)
- 10 Renal Disease Symposium; Pyelonephritis; Acute Renal Failure; Renal Tubular Acidosis; at Hazleton St. Gen. Hosp. (77-1-37)
- 10 Treatment and Management of Cervical Carcinoma; at Nesbitt Mem. Hosp., Kingston (77-1-285)
- 11 Septic Shock Etiology Pathogen Management; at Williamsport Hosp. (77-1-38)
- 12-13 Advances in Clinical Practice; at Sheraton Inn, Danville (77-1-205)

14-18	Diagnostic Ultrasound-Echocardiography; at Episcopal Hosp., Phila (77-1-107)	1-2	The Glaucoma Patient, at Wills Eye Hosp. (77-1-74)
15	Individual Psychotherapy. Psychoanalytic Behavior, Client-Centered. Hypnosis, Direct Analysis; at Woodville St. Hosp., Carnegie (77-1-35)	5	Concepts of Normality; at Woodville St. Hosp., Carnegie (77-1-35)
16	Peripheral Vascular Disorders and Phlebo-embolic Disease; at Hanover Gen. Hosp. (77-1-329)	6	Abdominal Diseases: The Internist and the Surgeon, at Geisinger, Danville (77-1-211)
17	Renal Disease Symposium; Management of Chronic Renal Disease; Dialysis and Transplant in Renal Failure; at Hazleton St. Gen. Hosp. (77-1-37)	6	Practical Advances in Dermatology, at Geisinger, Danville (77-1-210)
18	Endocrinology; at Williamsport Hosp. (77-1-38)	7	Dx and Rx of Gout; at Hazleton St. Gen. Hosp. (77-1-37)
21-23	Occupational Respiratory Disease; by Hahneemann, Phila. (77-1-182)	12	Review and Summary; at Woodville St. Hosp., Carnegie (77-1-35)
22	Group Psychotherapy: Family Therapy; Multiple Therapists; Psychodrama; at Woodville S. Hosp., Carnegie (77-1-35)	13	Early Diagnosis of Malignancies; at Allentown-Sacred Heart Hosps. (77-1-39)
23	Birth Injuries and Their Future Impact; at Allentown-Sacred Heart Hosps. (77-1-39)	13	Emergency Dept. Radiology, by Temple (77-1-126)
23	Hypertension, 1977; at Geisinger, Danville (77-1-206)	13	Eye Problems in General Practice; at Hanover Gen. Hosp. (77-1-331)
24	Anaerobic Infections; at Hazleton St. Gen. Hosp. (77-1-37)	14	Basics and Clinical Application of Arterial Blood Gases; at Nesbitt Mem. Hosp., Kingston (77-1-287)
24	Hematuria; at Good Samaritan Hosp., Pottsville (77-1-40)	14	Disorders of Fluid, Electrolyte, and Acid Base Balance, at Hazleton St. Gen. Hosp. (77-1-37)
25	Concepts of Renal Transplants; at Williamsport Hosp. (77-1-38)	15	Obstetrical Anesthesia, at Williamsport Hosp. (77-1-38)
28	Medical and Psychiatry Continuing Education; at Allentown St. Hosp. (77-1-177)	18	Medical and Psychiatry Continuing Education; at Allentown St. Hosp. (77-1-177)
		18-20	Cancer Chemotherapy II; by Hahneemann, Phila. (77-1-183)
		18-22	Diagnostic Ultrasound-Advanced Abdominal Scanning; at Episcopal Hosp., Phila. (77-1-106)
		20	A Day of Pediatric Nephrology; at St. Christopher's Hosp. for Children, Phila. (77-1-114)
		20	Pulmonary Physiology Made Easy: A Guide to the Understanding of Pulmonary Function Testing, at Geisinger, Danville (77-1-212)
		21	Recent Progress in Diabetes Mellitus; at Hazleton St. Gen. Hosp. (77-1-37)
		21	Seminars for the Family Physician; at St. Margaret Mem. Hosp., Pittsburgh (77-1-43)
		22-24	Fourth Annual Symposium for Nurse Anesthetists; at Pittsburgh Hilton Hotel (77-1-346)
		23	Clinical Skills Day, at Sugarloaf Conference Center, Phila. (77-1-127)
		25-29	Family Practice Review Course; at Landis Valley Motor Inn, Lancaster (77-1-128)
		27	Diabetes and the Eye; at Allentown-Sacred Heart Hosps. (77-1-39)
		27	Stauffer Memorial Lecture; by Temple (77-1-129)
		28	Gynecologic Endocrinology; at Hazleton St. Gen. Hosp. (77-1-37)
		28	Treatment of Bronchial Asthma; at Good Samaritan Hosp., Pottsville (77-1-40)
		29	Primary Health Care; at Williamsport Hosp. (77-1-38)
		29-30	Cardiopulmonary Resuscitation Course (77-1-347)
		29-30	Oculo-Plastic Surgery; at Bellevue-Stratford Hotel, Philadelphia (77-1-73)

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1	Organic Therapies; Milieu Therapy; at Woodville St. Hosp., Carnegie (77-1-35)
3	Pathologists Meeting; at Jeanes Hosp. (77-1-82)
3	Viruses as Infective Agents; at Hazleton St. Gen. Hosp. (77-1-37)
3-4	A Multidiscipline Approach to Orbital Disorders; at Univ. Health Center of Pittsburgh (77-1-339)
4	Genetics and Genetic Counseling; at Williamsport Hosp. (77-1-38)
4-5	Retinal Diseases of the Young and Adolescent; at Marriott Hotel, Philadelphia (77-1-75)
7	New Developments in Otolaryngology of Interest to Primary Care Physicians; at Geisinger, Danville (77-1-207)
7-11	Introductory Diagnostic Ultrasound, at Episcopal Hosp., Phila. (77-1-105)
8	Child Psychiatry; at Woodville St. Hosp., Carnegie (77-1-35)
9	Productive Values and Efficiency of Medical Diagnosis; at Allentown-Sacred Heart Hosps. (77-1-39)
10	New Management of Hypertension; at Nesbitt Mem. Hosp., Kingston (77-1-286)
10	Pneumoconiosis; at Hazleton St. Gen. Hosp. (77-1-37)
10-12	Phaco-Emulsification: Surgical Techniques; at Eye and Ear Hosp. (77-1-340)
11	Clinical Spectrum in Mitral Valve; at Williamsport Hosp. (77-1-38)
11-12	Cardiopulmonary Resuscitation Course (77-1-341)
15	Community Psychiatry; at Woodville St. Hosp., Carnegie (77-1-35)
16	A Day in Pediatric Cardiology; by Temple (77-1-123)
16	High and Low Blood Sugars and What to do About Them; at Geisinger, Danville (77-1-208)
17	Acute Hemorrhagic Shock; at Hanover Gen. Hosp. (77-1-330)
17	The Cardiac Examination; at Hazleton St. Gen. Hosp. (77-1-37)
17-18	Frontiers of Psychotherapy; at University City Holiday Inn, Phila. (77-1-124)
18	High Risk OB; at Williamsport Hosp. (77-1-38)
18-20	American Urological Association Meeting; at Pittsburgh Hilton Hotel (77-1-342)
21	Medical and Psychiatry Continuing Education; at Allentown St. Hosp. (77-1-177)
21	Urology Course; Caracas, Venezuela (77-1-125)
22	Geriatric Psychiatry: Forensic Psychiatry; at Woodville St. Hosp., Carnegie (77-1-35)
23	Pros and Cons of Multiphasic Screening Program; at Allentown-Sacred Heart Hosps. (77-1-39)
24	Appendicitis, the Acute Surgical Abdomen; at Hazleton St. Gen. Hosp. (77-1-37)
24	Errors in Emergency Practice, at Good Samaritan Hosp., Pottsville (77-1-40)
25	IV Nutrition-Hyperalimentation; at Williamsport Hosp. (77-1-38)
27-30	Clinical Immunopathology; at William Penn Hotel (77-1-343)
29	Etiology; at Woodville St. Hosp., Carnegie (77-1-35)
30	Immunology for the Practitioner; at Geisinger, Danville (77-1-209)
31	Pain Control: Medical, Psychological & Psychiatric Aspects; at EPPI (77-1-79)
31	Total Joint Replacement (Emphasis on Indications and Results); at Hazleton St. Gen. Hosp. (77-1-37)

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1	Respiratory Failure in Pediatric Age Group; at Williamsport Hosp. (77-1-38)
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2-4	Phaco-Emulsification: Surgical Techniques; at Eye and Ear Hosp. (77-1-350)
2-6	Diagnostic Ultrasound-Echocardiography; at Episcopal Hosp., Phila. (77-1-107)
4	Hypothyroidism and Thyrotoxicosis; at Geisinger, Danville (77-1-213)
5	Immune Mechanisms in Disease; at Hazleton St. Gen. Hosp. (77-1-37)
6	Anemia in Childhood; at Williamsport Hosp. (77-1-38)
7	Special Child Conference-9th Annual; at Geisinger, Danville (77-1-214)
8-12	Therapeutics; by Hahneemann, Phila. (77-1-185)
11	The Collagen Diseases; at Hanover Gen. Hosp. (77-1-332)
11	Which Newly Discovered Hypertension Patient Should be Evaluated Extensively; at Allentown-Sacred Heart Hosps. (77-1-39)
12	Chemo and Cobalt Therapy in Oncology; at Nesbitt Mem. Hosp., Kingston (77-1-288)
12	Peripheral Vascular Disease—Medical and Surgical Management; at Hazleton St. Gen. Hosp. (77-1-37)
13	Evaluation of Gall Disease and Current Therapy; at Williamsport Hosp. (77-1-38)
15-17	Annual Conference on Pediatric Ophthalmology-Complications; at Hyatt House, Cherry Hill, N.J. (77-1-70)
16	Medical and Psychiatry Continuing Education; at Allentown St. Hosp. (77-1-177)
16-20	Selected Subjects in Internal Medicine; at William Penn Hotel (77-1-351)
19	Granulomatosis Disease; at Hazleton St. Gen. Hosp. (77-1-37)
19-21	Annual Convention, PAO&O; at Bedford Springs Hotel (77-1-71)
20	Family Planning Update; at Williamsport Hosp. (77-1-38)
25	Oculopneumoplethysmograph (Evaluation of Stroke Prone Patients); at Allentown-Sacred Heart Hosps. (77-1-39)
26	Eye—Systemic Disease; at Good Samaritan Hosp., Pottsville (77-1-40)

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1	The Worried Well: Practical Approaches to Problem Patients; at Geisinger, Danville (77-1-215)
2	Pathologists Meeting; at Jeanes Hosp. (77-1-82)
3	H. Influenza-Bacterial Infections-Viral Infections; at Williamsport Hosp. (77-1-38)
6-10	Diagnostic Ultrasound-Cross-Sectional Anatomy; at Episcopal Hosp.,

- Phila. (77-1-108)
- 7-10 26th Annual Seminar in Pediatrics, at Benjamin Franklin Hotel, Phila. (77-1-11)
- 8 Coronary Bypass; at Allentown-Sacred Heart Hosps. (77-1-39)
- 8 The Significance of the Apical Systolic Murmur; at Geisinger, Danville (77-1-216)
- 10 Liver Disease and Pancreatic Disease; at Williamsport Hosp. (77-1-38)
- 16 Radiologic and Nuclear Medicine in Diagnosis and Therapy: Mammography, Xerography, Thermography and the EMI; at Hanover Gen. Hosp. (77-1-333)
- 17 Colposcopy; at Williamsport Hosp. (77-1-38)
- 19-23 1st International Facial Nerve Symposium in the USA, at Pittsburgh Hilton Hotel (77-1-355)
- 20 Medical and Psychiatry Continuing Education; at Allentown St. Hosp. (77-1-177)
- 22 Renal Transplant; at Allentown-Sacred Heart Hosps. (77-1-39)
- 24 Portal Hypertension—Diagnosis and Treatment; at Williamsport Hosp. (77-1-38)
- 24-25 Thrombosis Course; at Marriott Motor Inn, Bala Cynwyd (77-1-130)

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Classifying is done by sponsor. Activities shown under any given subject are generally of a quality that would be helpful to specialists in that field. Registration may be open to others.

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Philadelphia; MCP (77-1-256 and 257)
Philadelphia; Temple (76-2-146 and 77-1-122, 135, 151, 155 and 165)
Pittsburgh; Allegheny (76-2-74-78 and 77-1-19)
Pittsburgh; Mercy (76-2-24 and 25)
Pittsburgh; Pitt (76-2-82, 94, 97, 98, 100 and 77-1-320 to 322, 334, 337, 340, 344, 350, 352, 356 and 387 to 390)
Pittsburgh; Shadyside Hosp. (77-2-3)
Pittsburgh; West Penn (76-2-80, 88, 94-101, 111-114, 118 and 119)

UROLOGY

Danville; Geisinger (77-1-279 to 81)
Drexel Hill; Delaware Co. (77-1-67)
Philadelphia; Jeanes (76-2-138)
Philadelphia; Temple (77-1-125 and 164)
Pittsburgh; Pitt (77-1-342 and 374)
Pittsburgh; West Penn (76-2-93)

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List below all hours in which you participated in any type of continuing medical education activity.

List below all hours in which you participated in any type of continuing medical education activity.

Total number of hours spent in Category 1 activities (carry forward to next page):

Please check if you have:

- (no other data is required)

(name)

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535 N. Dearborn St.

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**Council on Education and Social Policy
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Sponsor: Institution, or Publication, or Physician, or Self	Location City State	Description of Learning Activity (Course, paper, journal, self-assessment prgm., etc.)	Dates of Attendance (inclusive)	Hours of Study	TOTALS
Brought Forward from Previous Page: Total number of hours spent in Category 1 activities:					
CATEGORY 2: C.M.E. Activities with Non-accredited Sponsorship (There is a limit of 45 credit hours here.)					
		Total number of hours spent in Category 2 activities:			
CATEGORY 3: Medical Teaching (There is a limit of 45 credit hours for this category.)					
		Total number of hours spent in Category 3 activities:			
Category 4: Papers, Publications, Books and Exhibits (There is a 40 credit hour limit for this category.)					
		Total number of hours spent in Category 4 activities:			
CATEGORY 5: Non-supervised Individual C.M.E. Activities (There is a limit of 45 credit hours for this category. Not more than 22 credit hours may be claimed in any one subcategory.)					
		Total number of hours spent in Category 5 activities:			
CATEGORY 6: Other Meritorious Learning Experiences (There is a 45 credit hour limit. Attach description) Total number of hours spent in Category 6 activities:					

TOTAL CREDIT HOURS - Completed During the Three Year Qualifying Period Immediately Preceding

Name and Address:

Medical Education Number:

Signature:

(from Membership card)

Federal Trade Commission suit against AMA analyzed

F. PETER KOHLER, M.D.

Bryn Mawr

The Federal Trade Commission has instituted suit against the American Medical Association. The suit, in essence, claims that the professional standards of ethics promulgated by the American Medical Association prohibit advertising by physicians in any form and thereby these ethics are a form of restraint of trade and in the final analysis by restriction of competition prevent a possible gradient of fees. It is the Federal Trade Commission's belief that advertising by medicine's professionals in the long run would reduce fees and thereby the cost of medical care.

This climate of thought was brought about by a decision of the United States Supreme Court in favor of Mr. Goldfarb. Mr. Goldfarb wished to buy a house in Virginia and found that the charges of all Virginia lawyers for settlement services were the same because the fees were established through schedule by the Virginia Bar Association for such services. Mr. Goldfarb then instituted suit against the Virginia Bar Association for restraint of trade and the United States Supreme Court found the Virginia Bar Association at fault.

There are several segments of American medicine which have guidelines for fees on a relative value schedule and one such segment is the American Society of Anesthesiologists. They became a special target of the Federal Government. But what escaped the thinking of the bureaucrats at the Federal Trade Commission is the fact that in this day and age a large segment of American medicine has its fees regulated willy-nilly by federal or local government agencies such as medicare, medicaid, Champus, etc. Although it may not be publicly known or openly accepted by the medical profession or government policy makers, fees are absolutely regulated by these programs. It is accomplished by a mechanism called the "usual and customary fee" in a given area, and the payments received from these agencies for medical services do not vary by one cent. In some states the usual and customary payment plan of Blue Shield programs have the same effect.

Let us now say that Mr. Goldfarb is over 65 years old, has medicare coverage and he finds that he needs an operation of some kind, suppose an

Dr. Kohler is the president of the Delaware County Medical Society. The article is reprinted from the Delaware County Medical Society Bulletin.

inguinal hernia. He tours the Virginia landscape consulting a half dozen surgeons and finds that each surgeon quotes him a fee of \$400 for repairing this defect. The reason that all surgeons quote this figure stems from the fact that this amount of reimbursement, let us say, represents the usual and customary fee paid by medicare to the providers of medical care in Virginia for this procedure on an assignment basis. This represents not a payment schedule by the Virginia Medical Association, nor by the American Medical Association, nor by the American College of Surgeons, but by the Social Security Administration as administrator of the medicare program and, therefore, the Federal Government itself.

To continue our hypothetical train of thought: Comes now Mr. Goldfarb and institutes suit against the Social Security Administration and comes now the Federal Trade Commission and institutes suit against the Social Security Administration, both for restraint of trade of the medical profession by price fixing through the "usual and customary fee" rates on an assignment basis. Or in other words a federal government agency would be instituting suit against another federal government agency. It would be lovely, indeed, contemplating for this to happen and constitutional lawyers and lawyers knowledgeable in the practice and wisdom of federal law might have many pleasant arguments over many martinis pro and con the merits of the issue. But practical lawyers like Mr. Newton Minnow—former Commissioner of the Federal Communications Commission—and, therefore, blessed with insight into the workings of such government establishments—point out that constitutionally everybody is equal under the law in these United States; except, of course, the Federal Government itself. It is a little more equal. Mr. Minnow considers such a hypothetical course of events philosophically and logically speaking a meritorious process of deduction, but for practical purposes, hopeless.

One of the reasons why the American Medical Association was formed back in 1847 was to put an end to the advertising of quacks and unethical and unscrupulous "professionals" through strict supervision of ethical standards and requirements of professional training and conduct. If the Federal Trade Commission seeks a return of the pre-1847

standards of medical practice let it pursue its ambition in this venture, and let it openly and without restriction assume full responsibility for the ensuing events.

It has been said by Michael Oakeshott that to some people government appears as a vast reservoir of power which inspires them to dream of what use might be made of it. They have favorite projects of various dimensions, which they sincerely believe are for the benefit of mankind and to capture this source

of power, if necessary to increase it, and to use it for imposing their favorite projects upon their fellows is what they understand as the adventure of governing men. They are thus disposed to recognize government as an instrument of passion; the art of politics is to inflame and to direct desire.

But one would hope that a more reflective and objective citizenry might plead with Oliver Cromwell: I beseech you—in the Bowels of Christ—think it possible you may be mistaken.

Rationing medical care

KENNETH B. JONES

Clearly the most important question facing medicine in the next decade is how to contain medical costs; or, to put it more bluntly, how to ration medical care. Yet the rationing question has barely been discussed by medicine, despite increasing evidence of its importance. Pennsylvania joins a host of other states in overspending its medicaid budget. The *increase* in the medicare portion of HEW's budget equals HEW's budget for all other programs. Cost control mechanisms like PSROs and HSAs are instituted and HMOs are funded as a means of reducing hospital utilization. President Ford, supporter of the free enterprise system, considers price controls on medicare. The total health care budget increased from \$12 billion in 1950 to about \$135 billion in 1976 and to nearly 10 percent of the gross national product.

The rationing question does not arise in the pure free enterprise system for price is the rationing method. Since World War II, however, health care has been moving away from a free enterprise system toward a third party payer system. During and after World War II we saw an increasing reliance on the private third party carriers for payment of medical care, and the 1960s saw government join the private carriers to the point where government now spends 40 percent of the total health care dollar. Medical care has increasingly become a "free" service to the individual. Increasingly there is no direct dollar related decision for the individual deciding whether or not to purchase medical care. The demand for free service is, in theory, unlimited.

There has been a barrier to translating this unlimited demand for service into effective demand—into real dollars spent. That barrier has been the supply of physicians which, until the late 1960s,

remained stable in the face of increases in demand. People didn't buy as much medical care as they might have for medical care was difficult to get. Efforts to solve this "physician shortage" are now beginning to show results and the supply of physicians is increasing. As their supply increases, more of the unlimited demand for services will be translated into real dollars spent.

In reality, there is a point where the demand for "free" service would be met even if the trend toward increasing supply of physicians and increasing third party coverage continue. Everyone would have all the medical care they would want. That point will not be reached soon, but before it is reached rationing or controls on supply or demand will be instituted, partly because total cost will be greater than this nation's other priorities will allow and partly because the increased expenditures for medical care are showing marginal effects on the general health. So the issue is not one of cost control/rationing versus no cost control/rationing. The issue is what form will cost control take, or, to put it another way, what rationing method will replace the price rationing method.

The cost control/rationing possibilities are almost endless, ranging from a federalized health care system with a cap on total federal spending to a return to the free enterprise price mechanism. In between these extremes there are partial solutions, some already in place, such as Health Service Agencies, copayment for health services, PSROs, increased health education, and seat belt laws.

Medicine cannot realistically adopt the position that it is opposed to all cost control/rationing methods and in favor of increased third party coverage and new spending in underfinanced areas of health care. To adopt that position is to hasten the day when an arbitrary system is imposed and to insure that medicine will have no voice in what form that rationing system will take.

Mr. Jones served as staff assistant to the Society's Commission on Manpower during the five years he was a member of the Society staff. Currently he is studying health law at Boston College.

Treatment of suspected victims of sexual assault

The Hospital Association of Pennsylvania and the Pennsylvania Medical Society have prepared the following guidelines to assist hospitals in complying with the special needs of suspected victims of sexual assault.

Sexual assault is one of this country's fastest growing crimes. Victims of such crimes have four basic needs: information and emotional support; prompt, complete, and sympathetic medical treatment; unbiased, sensitive treatment by police; and reasonable protection from harassment when reporting the crime or serving as a witness. These guidelines were prepared in an effort to establish appropriate resources in health facilities so that suspected victims can be treated properly and evidentiary material can be preserved.

I. Introduction

The treatment of suspected victims of sexual assault requires close cooperation and coordination of the patient, family, friends, medical staff, hospital personnel, legal authorities, and community. The patient should be advised and prepared of the necessity of various tests and procedures to be followed in order to provide proper treatment and assist legal authorities in the collection of evidence. A sympathetic person (i.e., family member or hospital staff member) should remain with the patient through the entire process in the event the patient desires such support. If the patient's clothing is to be retained for evidence, provision should be made for appropriate clothing if the patient is to be discharged.

Of overriding importance is for the hospital staff to offer support to the victim and to express concern for her in a time of trauma and crisis. The staff's responsibility to collect, record, and preserve evidence for the police should not be in conflict with the expression of empathy and attitude of helpfulness towards the victim who has come for treatment.

II. Proper setting

Recognition should be made that sexual assault is a violation of both mind and body, often bringing great mental and physical anguish. It is essential that the patient be treated promptly, carefully, and sympathetically. Examination of and consultation with the patient should take place in a private setting. Similar facilities should be made available for use by the police in their interrogation of the patient. A sympathetic person (i.e., family member or hospital staff member) should remain with the patient through the police interrogation in the event the patient desires such support.

Hospital personnel should refer to such cases by code (e.g., code R) so that comments such as "Where's the rape?" are avoided. To minimize guilt feelings, family and friends should be cautioned to avoid using terms such as "ruined," "violated," or "dirty" or "loss of innocence." Facetious or ribald comments should not be condoned.

III. Notification of authorities and parents

A. Notification of Police

According to Pennsylvania law (18 P.S. Section 5106),

notification of the police must be made in cases in which there is physical abuse, in which the suspected victim claims sexual assault or in which there is a reasonable belief that sexual assault has occurred. The report must state the name and the whereabouts of the suspected victim and the nature and extent of any injuries.

B. Notification of Child Protective Services Organization

If the suspected victim is less than eighteen (18) years of age, Pennsylvania law (11 P.S. Sections 2201-2224) requires immediate notification of the statewide **Childline: (800) 932-0313**. The report should have available and provide the following information:

1. The names of the child and his/her parent, guardian, or other responsible person.
2. The date(s), nature, and extent of the suspected abuse.
3. The home address(es) of the child and parent, guardian, or responsible person.
4. The age of the child.
5. The locality in which the suspected abuse occurred.
6. The progress of legal proceedings, if any, already instituted on the basis of the suspected abuse.

In addition to the mandatory oral report to the **Childline**, the reporting person may also orally notify the local Child Protective Services organization. Within 48 hours of the initial oral report to the **Childline**, the person required to report must make a written report to the local Child Protective Services organization. Generally, the examining physician is responsible for making this report.

C. Notification of Parents or Legal Guardian

1. Notification and consent of the parent or legal guardian should be made for all persons less than eighteen (18) years of age.
2. Notification and consent of the parent or guardian is not required if:
 - a. The person is eighteen (18) years of age or older.
 - b. Person has graduated from high school.
 - c. The person is or has been married.
 - d. Person is or has been pregnant.
 - e. In the judgment of the physician, an attempt to obtain consent would result in delay of treatment and increase the risk to the minor's life or health.
 - f. To determine the presence of or to treat pregnancy

or venereal disease (Disease Prevention and Control Act of 1955, 35 P.S. Section 10101 *et seq.*).

D. Release of Information (additional)

Hospitals are not required to release information about suspected victims of sexual assault to the public, press, or outside supportive agencies without the consent of the victim. (65 P.S. Section 66.1 *et seq.*).

IV. Consent

Written and witnessed consent for the following should be obtained:

- A. Examination and laboratory procedures including blood alcohol and urinalysis.
- B. Photographs.
- C. Release of information to proper authorities.

V. History

A medical history should be obtained. The use of direct quotations by the suspected victim has, in actual experi-

ence, proved counterproductive and should be avoided. A statement of each of the following is desirable:

- A. Time and place of the incident.
- B. Relation of the assaulter, if any.
- C. The nature of the suspected physical and sexual act(s).
- D. Time interval between the assault and the examination.
- E. Patient's physical state.
- F. Whether the patient has taken a bath since the time of assault.

It should be noted that description of the attacker and issues surrounding provocation are clearly within the province of the police and not a matter for the examining physician.

VI. Examination, treatment, and followup

- A. Examination (see also Appendix 1)

A complete examination should be performed. All findings should be noted in the medical record.

- 1. General appearance: bruises, lacerations, torn or bloody clothing, and condition of the patient.
- 2. External genitalia: evidence of trauma.
- 3. Internal examination: inspect cervix and vagina with a nonlubricated, but water-moistened speculum.

- B. Treatment

- 1. Prophylactic treatment for venereal disease should be initiated in all cases of suspected rape, unless contraindicated.
- 2. Prophylactic treatment for the prevention of pregnancy may be indicated. (NOTE: In the case of any hospital or health care facility which has a policy of refusal to perform abortions, treatment to terminate pregnancy should not be deemed to be standard or required treatment in that facility.)

- C. Followup

- 1. Treatment of contusions, lacerations, etc.
- 2. Surveillance for venereal disease.
- 3. Surveillance for pregnancy.
- 4. Counseling to prevent any significant, long-term harmful psychological effects.

VII. Evidentiary material

Evidentiary material should be gathered and held for possible release to the police. Absent from appropriate subpoena or court order, such material should not be released without the consent of the patient (or parent or guardian in the event the patient is a minor).

Specimens should be collected and handled as follows:

A. Swab from the vaginal pool, and from any suspicious area about the vulva. Protect in a test tube. These can be examined by a hospital or police laboratory for:

- 1. Acid phosphatase.
- 2. Blood group antigen of semen.
- 3. Precipitin test against sperm and blood.

B. Wet sample from fornix examined immediately for motile sperm. This examination should be performed only

SAMPLE	
CONSENT FOR EXAMINATION	
MEDICAL EXAMINATION	
Patient No. _____	Name _____
Date _____	Address _____
Time _____	City _____
Witness _____	Guardian _____
CONSENT FOR EXAMINATION	
I hereby authorize Dr. _____ and Dr. _____ to perform a complete medical examination, including pelvic (internal) examination, on my person and record for the proper law enforcement agency their findings as related to the prosecution of my assailant(s).	
I further authorize the collection of necessary specimens for laboratory tests, and the taking of necessary photographs by a competent photographer for the purposes of prosecution of my assailant.	
AUTHORIZATION FOR RELEASE OF INFORMATION	
I hereby authorize the _____ Hospital to supply copies of ALL medical reports including any laboratory reports and/or photographs immediately upon completion to the Police Department and the Office of the District Attorney having jurisdiction.	
Person Examined _____	
Address _____	
Parent or Guardian _____	
Date _____	
Witness _____	

Appendix 1

A. Equipment Recommended For Evidentiary Material

1. Fresh sealed package of microscopic slides with frosted ends.
2. Eye dropper bottle with 0.9 percent saline.
3. 6-12 packages of sterile cotton swabs.
4. 8-12 test tubes with stoppers.
5. Urine container.
6. Sterile new comb.
7. Sterile scissors.
8. Nail scraper—plastic or orangewood.
9. Envelopes.
10. Package of gummed labels.
11. Glass-cutting pencil.

B. Physical Examination

1. Patient's clothes:
 - (a) Look for tears, blood, semen, stains.
2. Preserve, mark, and photograph these or turn over to police laboratory.
3. Full physical examination:
 - (a) Vital signs, general appearance, and mental status.
 - (b) Identify and measure cuts, bruises, and scratches.
 - (c) Are fingernails broken?
 - (d) Look for extragenital sexual trauma—mouth, breasts, neck.
4. Pelvic examination:
 - (a) Observe for matted hair or free hair.
 - (b) Describe vulvar trauma—redness, lacerations, bruises.
 - (c) Condition of hymen.
 - (d) Condition of anus and rectum.
 - (e) Vaginal examination—use unlubricated, water-moistened speculum.
 - (f) Look for discharge blood and lacerations of cervix—evidence of trauma.
 - (g) Uterus—size (pregnancy?).
 - (h) Adnexa—? hematoma.

by an experienced person who understands the limitations of examining sperm material.

C. Separate smears from vulva.

D. Culture for *Neisseria* in appropriate medium such as Thayer-Martin.

E. Comb pubic hair for free hairs; clip 5-10 patient pubic hairs (optional).

F. Fingernail scrapings (optional).

Laboratory specimens should be obtained by a physician in the presence of a witness, and personally handed to the pathologist or technician. Clearly label slides and containers with the patient's name. A signed receipt dealing with what the lab received and when from the laboratory should be given to the examining physician.

If the patient's clothing is torn, bloody, or soiled, the physician and other hospital staff members should advise the patient that turning such clothing over to the police may be helpful in their investigation.

It is important that a "chain of evidence" be maintained. That is, a form should be developed to insure that all persons who were responsible for keeping or handling the evidentiary material can be easily traced. It is advisable that evidence be handled by as few personnel as possible. When giving the material to a police representative, a

receipt of the material should be obtained showing what items were given to the police, who gave them to the police, the date and time of the transfer, the name of the police representative to whom the items were given.

The hospital should establish a policy as to *who is responsible* for:

- A. Collecting the various specimens and other evidentiary material.
- B. Retaining evidentiary material.
- C. Obtaining consent for release of evidentiary material.
- D. Notifying the police that evidentiary material is available for collection.
- E. Turning the evidentiary material over to the police.

VIII. Medical records

The medical record should contain documentation of the history, examination, and treatment of the patient. It should give descriptions of the physician's findings and what was done. It should state to whom he delivered specimens, clothing, or photographs. Physicians should express only medical conclusions, opinions, or diagnosis in the medical record. The medical record must be legible, preferably typed.

The physician should remember that he and the medical record may be subpoenaed and that he may be required to testify. All information should be exact and detailed to avoid any misinterpretation. Negative findings are as important as positive ones and may assist in the protection of all concerned.

IX. Transfer

A patient claiming to be the victim of sexual assault should be treated as a medical emergency as often the patient will have suffered physical and emotional trauma warranting such treatment. In many cases, prompt and effective treatment may be necessary to prevent prolonged effects of such trauma. Health facilities not equipped or staffed to provide treatment to these patients should *offer to arrange for transfer* of the patient to a health facility which has such capability, and with whom prior arrangements have been made to avoid delay.

X. Provision of crisis counseling

It is advisable for the medical staff and the hospital personnel to be aware of all community and in-hospital support staff and programs for the patient. The hospital should be sure a hospital staff member or other qualified person or agency is available to provide counseling services. Rape victim counseling should be provided only by qualified personnel.

Additional Reading

1. American College of Obstetricians and Gynecologists, "ACOG Technical Bulletin Number 14," July, 1970, 79 West Monroe Street, Chicago, IL 60603.
2. Chicago Hospital Council, "Guidelines for the Treatment of Suspected Rape Victims," 840 North Lake Shore Drive, Chicago, IL 60611.
3. Enos, William F. et al. "A Laboratory Procedure for the Identification of Semen: A Preliminary Report," *The American Journal of Clinical Pathology*, Vol. 39, No. 3, pp. 316-320, March, 1963.
4. McCubbin, Jack H., and Daniel E. Scott, "Management of Alleged Sexual Assault," *Texas Medicine*, Vol. 69, pp. 59-64, September, 1973.
5. Pennsylvania Commission for Women, "Help for the Rape Victim," Commonwealth of Pennsylvania, 512 Finance Building, Harrisburg, PA 17128.

Congenital mesocolic hernia

DOMINGO T. ALVEAR, M.D.

ROBERT JACOBS, M.D.

Harrisburg

Congenital mesocolic hernia is a rare developmental anomaly consisting of a sac filled with variable amounts of small intestine lying behind the mesentery of the colon.¹ It can be found either behind the ascending or the descending mesocolon and is therefore known as a right or left mesocolic hernia, respectively.²

Most reports describe mesocolic hernias in an older age group; there are only scattered reports in the pediatric age group. (Table I)

Most of the patients presented as acute surgical emergencies and most

of the cases did not have operative diagnostic contrast study of the upper gastrointestinal tract. (Table I).

Dr. Alvear is attending pediatric surgeon and Dr. Jacobs is a resident in surgery at Polyclinic Hospital, Harrisburg. The authors wish to acknowledge Leonard W. Konikiewicz, director of the audiovisual department of the hospital, and Miss Sue Shultz for their help in the preparation of the paper.

Some of the hernias reported were discovered incidentally at autopsy.^{3,4,5}

Case report

A nine year old white female presented with a 1½ year history of episodic lightheadedness, dizziness, and vague abdominal pain. She had some nausea but no vomiting. There was no history of constipation, diarrhea, or abdominal distention. The described discomfort was not related with respect to time or volume of meals. The symptoms were at times exacerbated by erect posture and

TABLE I
Cases Studied

AGE	SEX	UGIs PERFORMED	BOWEL OBSTRUCTION	LOCATION	IS PRE-OP DX MADE?	REFERENCE
1 wk.	male	no	yes	left	no	5
2 mon.	male	yes	yes	left	no	13
5 yr.	male	no	yes	left	no	17
9 yr.	female	yes	no	left	yes	present case
13 yr.	female	no	yes	right		11
17 yr.	male	no	yes	right	no autopsy	11
22 yr.	female	yes	yes	left	no	18
24 yr.	male	no	no	left	autopsy	4
27 yr.	male	no	yes	right	no	11
27 yr.	male	no	no	left	no	3
27 yr.	male	no	yes	left	no	14
30 yr.	male	no	yes	left	autopsy	5
30 yr.	male	no	no	right	autopsy	3
31 yr.	male	yes	no	right	yes	15
35 yr.	male	no	yes	right	no	16
35 yr.	male	no	yes	left	no	17
38 yr.	female	no	yes	left	autopsy	5
41 yr.	female	yes	no	left	yes	1
42 yr.	female	no	yes	right	no	12
44 yr.	male	yes	no	right	no	1
44 yr.	male	no	yes	right	no	5
45 yr.	male	yes	no	left	no	1
47 yr.		yes	no	right	yes	15
53 yr.	female	yes	no	left	yes	10
59 yr.	male	yes	yes	left	yes	19
60 yr.	male	yes	no	right	no	11
61 yr.		yes	no	right	yes	15
61 yr.	male	no	no	left	yes	12
68 yr.	male	no	yes	right	no	1
75 yr.	female	no	yes	right	no	1
ADULT	male	no	no	left	autopsy	4



Figure 1A. Contrast study of the upper gastrointestinal tract showing essentially normal findings.



Figure 1B. Repeat study showing conglomeration of upper small bowel in the left side of the abdomen enclosed in a sac.

seemed to manifest as orthostatic hypotension. She was seen by her pediatrician on several occasions, but no therapy relieved her symptoms.

Five months prior to admission, a contrast study of the upper gastrointestinal tract was performed. The results were interpreted as pylorospasm (Figure 1A). The contrast material can be seen entering the jejunum, but no hernia sac is clearly outlined. Delayed followup films down to the colon were unrevealing. The patient continued to have episodes of nausea and abdominal discomfort with increasing frequency until a repeat contrast study of the upper gastrointestinal tract was again performed five months later. The stomach and duodenum appeared unchanged. The contrast material was carefully followed into the proximal and mid-jejunum, and a hernia sac was clearly outlined (Figure 1B).

Physical examination on admission with reference to the abdomen was entirely unremarkable. The laboratory data included: hemoglobin, 13.6; hematocrit, 39 percent; white blood cell count, 7,300 with a normal differential. Urinalysis, serum electrolytes,

and SMA-12 studies were normal.

At laparotomy, a defect at the mesocolon was seen (Figure 2), and a hernia sac was clearly demonstrated to lie within the mesentery of the ascending colon. The proximal jejunum was in the sac and was removed nor-

mally from the sac.

The defect in the mesentery was closed with interrupted #2-0 silk sutures, avoiding the inferior mesenteric vessel (Figure 3). The postoperative course was uneventful and the patient had no recurrence of

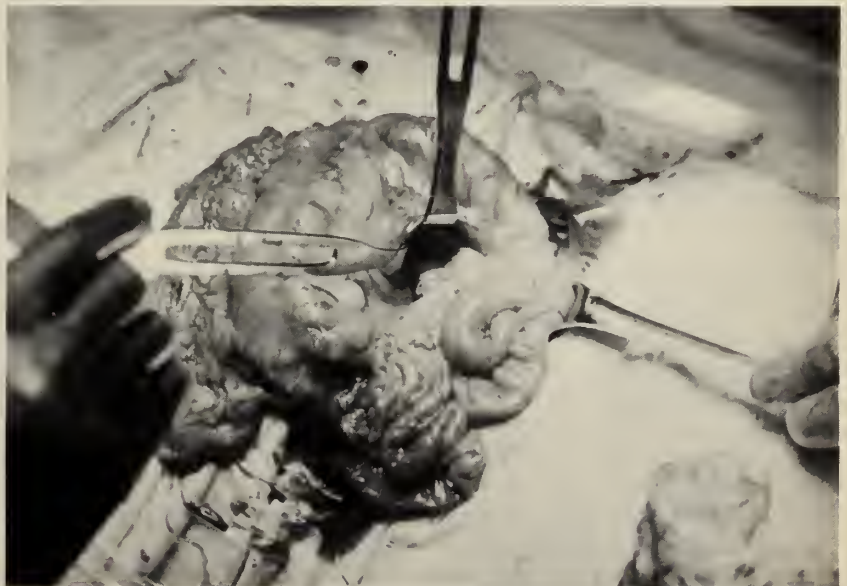


Figure 2. Defect in the mesocolon with the upper small bowel reduced from a retrogastric and retrocolic internal hernia sac.



Figure 3. Mesenteric defect has been closed with interrupted #2-0 silk sutures.

symptoms up to two years' followup.

Discussion

Congenital mesocolic hernia was commonly known as paraduodenal hernia because it was felt to arise from one of the many invaginations around the fourth portion of the duodenum.⁶ In more recent literature, however, it is felt that these paraduodenal fossae are unrelated to congenital mesocolic hernias, an opinion first voiced by Andrews in 1923.⁷

Callender, Rusk, and Nemir in 1936 described the embryology of congenital mesocolic hernias.⁸ They explained that a left mesocolic hernia results when the jejunum migrates to its normal position on the left side of the abdominal cavity, inadvertently invaginating the portion of the descending mesocolon bordered by the inferior mesenteric vessels. It comes to rest, therefore, trapped in a hernia sac composed of the mesentery of the descending colon with the inferior mesenteric vessels in close proximity

to the neck of the sac. The remainder of the rotational process is entirely normal; the duodenum, variable portion of the ileum, and the cecum are in their normal positions.

Right mesocolic hernias result when the pre-arterial segment of the midgut does not rotate as it should around the axis of the superior mesenteric artery. The cecum and the ascending colon rotate normally and trap the small intestine in a sac composed of the mesentery of the ascending colon.

The most common presentation is a picture of small bowel obstruction.⁹ The preoperative diagnosis is difficult unless a contrast study of the upper gastrointestinal tract is performed. The patients, however, are undoubtedly explored because of small bowel obstruction, so that the use of contrast study of the gastrointestinal tract may be redundant and dangerous. In a patient who has a long history of vague abdominal discomfort, a contrast study of the upper gastrointestinal tract with careful small bowel

follow-through is essential in making the diagnosis.

Once a diagnosis is made, surgical correction is the only effective modality.

Summary

A congenital mesocolic hernia which was diagnosed prior to causing a bowel obstruction in a pediatric patient has been presented. The use of a contrast study of the upper gastrointestinal tract with careful small bowel follow-through is emphasized to demonstrate the hernia sac. The treatment is surgical closure of the neck of the sac which is to be performed carefully to avoid injury to the mesenteric vessels. □

REFERENCES

1. Bartlett, Marshal K; Wang, Chiu-an; and Williams, Willis H. The surgical management of paraduodenal hernia. *Ann. Surg.*, 168:249, 1968.
2. Nyhus, L.N.; and Harkin, H.N., Eds. *Hernia*. Phila., Lippincott, 1964, p. 587.
3. Findlay, C.W., Jr; and Humphreys, G.H., II. Congenital anomalies of intestinal rotation in the adult. *International Abstracts of Surg.* 103:417, 1956.
4. Longacre, J.J. Mesentericoparietal hernia. *Surg., Gyn. & Obstet.*, 59:165, 1934.
5. Zimmerman, Leo M.; Laufman, Harold. Intra-abdominal hernias due to development and rotational anomalies. *Ann. Surg.*, 138:82, 1953.
6. Moynihan, B.A. *On retroperitoneal hernia*. London, Bailliere, Tindall & Cox, 1899.
7. Andrews, E. Duodenal hernia; Misnomer. *Surg., Gyn. & Obstet.*, 37:740, 1923.
8. Callender, C.L.; Rusk, G.Y.; Nemir A. Mechanism symptoms and treatment of hernia into the descending mesocolon (left duodenal hernia). *Surg., Gyn. & Obstet.*, 53:316, 1931.
9. Gray and Skandalakis. *Embryology for surgeons: the embryological basis for the treatment of congenital defects*. W.B. Saunders & Co. Phila. 1972. p. 146.
10. Willwerth, Ben M.; Zollinger, R.M., Jr; and Izant, R.J., Jr. Congenital mesocolic (paraduodenal) hernia; embryologic bases of repair. *Am. J. Surg.*, 128:358, 1974.
11. Bartlett, John, D., Jr.; Martel, William; and Lindenauer S. Martin. Right paraduodenal internal hernia. *Surg., Gyn. & Obstet.*, 132:443, 1971.
12. Coopwood, Thomas; Bricker, Donald L. Paraduodenal hernias. *S. Med. J.*, 65:1138, 1972.
13. Garza, Rodolf; and Sloan, J.M.; Paraduodenal hernia. *Texas Med.*, 64:46, 1968.
14. Kyosola, K. Strangulated left paraduodenal hernia. Complicating recovery from acute gangrenous appendicitis and peritonitis. *Annales Chirurgiae et Gynaecologiae Fenniae*, 62:165, 1934.
15. Mueller, Edwin, C. Congenital internal hernia. *Am. J. Surg.*, 97:201, 1959.
16. Sim, William, Graham; Skandalakis, John E.; and Gray, Slepten W. Right paraduodenal hernia into the fossa of Waldeyer. *J. Med. Assn. Ga.*, 60:105.
17. Singh, S.; Sachdeva, H.A.; and Pathak. Left paraduodenal hernia: report of two cases. *Can. J. Surg.*, 14:148, 1971.
18. Turner, Frank, W. Gangrene and rupture of the stomach, secondary to jejunal obstruction by an internal (paraduodenal) hernia; case report. *Can. J. Surg.*, 15:118, 1972.
19. Wilkinson, G.W. Left paraduodenal hernia: a new approach to etiology and treatment. *Can. J. Surg.*, 14:151, 1971.

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• Indicates membership in the Pennsylvania Society at time of death.

• **Robert C. Beswick**, Pittsburgh; University of Pittsburgh School of Medicine, 1943; age 61; died June 19, 1976. A pediatric physician for 30 years, he was on the staffs of Suburban General and Children's Hospitals, and was an associate professor of pediatrics for the University of Pittsburgh School of Medicine. He was a fellow of the American Academy of Pediatrics and past chairman of the Pennsylvania Pediatric Society. His wife, three sons, and a daughter survive him.

• **Claude P. Brown**, Philadelphia; Temple University School of Medicine, 1911; age 100; died June 10, 1976. A pathologist for 49 years until his retirement in 1969, he was proprietor of the Claude P. Brown Laboratories in Philadelphia, and former director of the Mulford Biological Laboratories of Glenolden. He was the first president of the Temple University Medical Alumni Association; a medical scholarship to Temple was named in his honor. He was a diplomate of the American Board of Pathology, a member of the American Association of Clinical Pathologists and the Pennsylvania Public Health Association. He is survived by a daughter.

• **John J. Burns**, Philadelphia; Jefferson Medical College, 1924; age 76; died June 11, 1976. He practiced medicine for 45 years until his retirement in 1970. His wife, two daughters, one of whom is Mary Ann Burns, M.D., two sons, one of whom is Robert B. P. Burns, M.D., and two brothers survive him.

• **Harry E. Feather**, Pittsburgh; University of Pittsburgh School of Medicine, 1926; age 73; died June 8, 1976. He was medical director of St. Francis General Hospital since 1966 and was on the hospital's board of directors and executive committee. He was an associate professor of surgery at the University of Pittsburgh School of Medicine. He was on the staffs of Magee-Womens and Presbyterian-University Hospitals, and on the consulting staffs of Children's, Eye and Ear, Woodville State, and Veterans Administration Hospitals. Certified by the American Board of Surgery, he was a fellow of the American College of Surgeons. His wife, a son, and a brother survive him.

• **Austin L. Hauslohn**, Rosemont; University of Pennsylvania School of Medicine, 1903; age 95; died June 4, 1976. He had practiced surgery for 60 years. A son survives him.

• **Elmer O. Headrick**, Mount Pocono; Jefferson Medical College, 1943; age 61; died June 18, 1976. He was presi-

dent of the Monroe County Medical Society in 1964. He had served as deputy coroner of Monroe County for more than twenty years. He is survived by his wife, three daughters, and two sisters.

• **Ralph F. Himes, Sr.**, Altoona; Jefferson Medical College, 1923; age 77; died June 15, 1976. He was president of the Blair County Medical Society in 1963, served on the county society board of directors 1963-64, and the board of censors 1968-69. He had served as chief of the department of otolaryngology and director of clinical surgery at Altoona Hospital. He was a fellow of the American and International Colleges of Surgeons and a diplomate of the American Board of Otolaryngology. His wife, a son, Ralph F. Himes, Jr., M.D., a brother, and a sister survive him.

• **Robert R. Janjigian**, Wyoming; Boston University School of Medicine, 1918; age 86; died June 7, 1976. He had headed the pathology laboratory at Wilkes-Barre General Hospital for over 25 years. Edward R. Janjigian, M.D., his brother, survives him.

• **Harry A. Kaplan**, Philadelphia; Jefferson Medical College, 1951; age 52; died July 2, 1976. He was medical director of the Riverview Hospital for the Aged. He had organized the family practice unit of Chestnut Hill Hospital, served as its director for one year, and served as head of the outpatient department for Albert Einstein Medical Center, Northern Division. His wife, two daughters, two sons, and a sister survive him.

• **Earle L. Keeter**, Pottsville; Hahnemann Medical College and Hospital, 1946; age 55; died June 6, 1976. His activities in the Schuylkill County Medical Society were numerous; he served as secretary 1964-74, president 1970, on the board of directors 1965 and 1971-73, on the board of censors 1971-73, and was a delegate to the State Society 1964-65 and 1967-75. He was a member of the Society's Council on Public Service 1971-74, and the Commission on Professional Liability Insurance 1970-74. He was medical director at the Leader Health Care Center and president of the staff at the Pottsville Hospital-Warne Clinic. His wife, parents, a son, and a sister survive him.

• **William W. Lerman**, Pittsburgh; Jefferson Medical College, 1916; age 82; died June 15, 1976. He had practiced gastroenterology for more than 50 years and was a member of the emeritus staff of Allegheny General Hospital. In 1972 he received the first president's citation from Thomas Jefferson University. He was a past president of the American College of Cardiology. Two sisters survive him.

• Indicates membership in the Pennsylvania Society at time of death.

• **Ralph W. Mays**, Jenkintown; University of Pennsylvania School of Medicine, 1932; age 68; died June 29, 1976. In 1950 he became an associate in medicine, and from 1958-68 was an associate professor of medicine for Jefferson Medical College. He was former director of the departments of medicine for Germantown Hospital and Jeanes Hospital. His wife survives him.

• **Aldo R. Mazzoni**, DuBois; University of Pittsburgh School of Medicine, 1950; age 57; died June 17, 1976. He was an orthopedic surgeon for South Side, St. Joseph, and DuBois Hospitals. He was a fellow of the International and American Colleges of Surgeons and a member of the Tri-State Orthopedic Association. His wife, a son, and a daughter survive him.

• **David G. Moyer**, Lansdale; New York University Medical College, 1941; age 65; died July 11, 1976. He was an instructor of athletic medicine at the Pennsylvania State University College of Medicine, traveling team physician for Lafayette College, and in 1972 served as an alternate physician for the U.S. Olympic team. He had served as resident pathologist, director of a well baby clinic, and associate director of an obesity clinic at Abington Memorial Hospital, and 1947-49 was acting chief of medicine at Jeanes Hospital. His wife, three daughters, and three sons survive him.

• **James J. O'Connor**, Barnesboro; Jefferson Medical College, 1916; age 86; died June 22, 1976. He had practiced medicine in Cambria County for 60 years. His wife, four sons, including Leo O'Connor, M.D., and John O'Connor, M.D., and a sister survive him.

• **William H. Regelman**, Jamison; Hahnemann Medical College, 1924; age 79; died June 10, 1976. Information regarding survivors is unavailable at this writing.

• **Faiz A. Rizvi**, Jeannette; Sylhet Medical School, Bangladesh, 1968; age 33; died June 24, 1976. He was on the surgical staffs of Monsour Medical Center and Jeannette District Memorial Hospital; previously he had been associated with McKeesport Hospital. His wife and a daughter survive him.

• **Theophil S. Tyran**, Sharpsville; Georgetown University School of Medicine, 1936; age 66; died June 13, 1976.

He had practiced in Sharpsville in 1938 and was on the medical staff of Sharon General Hospital. His wife, two sons, a brother, and a sister survive him.

• **Homer B. Wilcox, Jr., M.D.**, Philadelphia, University of Pennsylvania School of Medicine, 1940; age 61; died June 6, 1976. He was medical director of the Unitarian Universalist House, Stapeley Hall, and Lycoming House, Philadelphia. For 30 years he served as supervisor of the diabetes clinic at Germantown Hospital. Previously he had been an associate in medicine at Jefferson Medical College, Thomas Jefferson University, and served on the staff of Chestnut Hill Hospital. His wife, four sons, a daughter, and two sisters survive him.

Charles A. Behney, Tuscon, Arizona (formerly of Meyersdale); University of Pennsylvania School of Medicine, 1917; age 84; died May 12, 1976. A daughter, a son, and a sister survive him.

Leroy W. Kumperman, Penn Valley; Temple University School of Medicine, 1944; age 56; died May 28, 1976. In 1949 he was named acting head of Temple's department of anesthesiology and in 1950 became professor and chairman of the department, posts which he held until 1975. At the time of death he was on a leave of absence from Temple to serve as director of anesthesiology at the Veterans Administration Hospital in Dallas, Texas. He served as president of the Pennsylvania Society of Anesthesiologists in 1960, vice president of the Philadelphia Society of Anesthesiologists from 1955-57, assistant secretary of the anesthesia section of the American Medical Association from 1969-71, and an alternate director for the Pennsylvania district of the American Society of Anesthesiologists 1968-70. He was the founder of the Pain Control Center at Temple Hospital. Two sons, one of whom is Leroy W. Kumperman, M.D., and a sister survive him.

Henri Schmid, Allison Park; University of Pittsburgh School of Medicine, 1910; age 94; died February 4, 1976. A son survives him.

Julio C. Venegas, Yardley; San Marcos National University Medical School, Lima, Peru, 1955; age 46; died May 18, 1976. His wife survives him.

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Pennsylvania Medicine

OCTOBER 1976

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'In the subculture
of government
there prevails this
delusion . . . that
existence on paper
is existence in reality.'

Abraham J. Twerski, M.D. in
his series of articles,

*"Goto hell, Washington
and take Harrisburg
with you!"*



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medigram

IMMUNIZATION ALERT ISSUED

Robert D. Gens, M.D., director of the Health Department's Bureau of Adult Health Services, has issued

the following last minute bulletins on the A/New Jersey immunization program in the Commonwealth:

1. Supplies of monovalent and bivalent (A/New Jersey and A/Victoria) vaccine will arrive here early in October. The exact date is not set. Distribution of bivalent vaccine will begin immediately with private physicians receiving a proportionate share soon thereafter.
2. The dosage has been set at .5 ml and this effective dosage is the one to be used, even though smaller dosages of influenza vaccines have been used in the past.
3. PUBLIC LAW 94-380, SIGNED AUGUST 12, 1976, PROVIDING LIABILITY INSURANCE FOR THE IMMUNIZATION PROGRAM, IS VOID IF THERE IS A CHARGE FOR ADMINISTERING THE VACCINE. Pennsylvania's Act 187 of 1976, exempting agencies, hospitals, and nursing homes from liability in the immunization program, takes precedence over the federal law.
4. Pennsylvania has its own consent form, which is simpler than that federal government form and has federal government approval. A No. 2 pencil may be used to complete the form. Erasures are permitted.
5. High risk categories of the population are to be immunized first. While there are age high risk and disease high risk categories, there is no occupational high risk group. High risk groups are: (1) Those with heart disease of any etiology; (2) Those with chronic pulmonary disease; (3) Those with chronic renal failure; (4) those with diabetes mellitus; and (5) Those 65 years of age and older. THE DISEASE HIGH RISK GROUPS INCLUDE CHILDREN DOWN TO AGE THREE.
6. There are two types of A/New Jersey vaccine: whole virus vaccine and split virus vaccine. Those in the over 25 age group may be immunized with either type. Those between the ages of 18 and 24 must be immunized with whole virus vaccine and may need a second dose. Those in the high risk categories between the ages of 3 and 18 must be immunized with split virus vaccine in two doses four weeks apart.

Dr. Gens said the vaccine is expected to trickle in at first and that monovalent vaccine will be stockpiled as those in the high risk groups are immunized first with bivalent vaccine in the first phase of the immunization program which is expected to last 25 days.

CAPTIVE INSURANCE COMPANY FINANCING SET

The Pennsylvania Medical Society's House of Delegates unanimously approved a

financing mechanism for the Pennsylvania Medical Society Liability Insurance Company (PMSLIC) at the annual meeting at the Bellevue-Stratford Hotel, Philadelphia, September 16-18. The nearly 200 delegates authorized the Board of Trustees to assess each member up to \$500 to raise part of the nearly \$6 million needed to capitalize the company, formation of which was authorized at the special session of the House of Delegates on July 11. Since the Society's agreement with Argonaut Insurance Company is still in effect, delegates authorized the Board to activate the company at such time as it may be needed. The assessment may not be levied as long as Argonaut is

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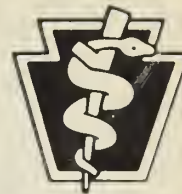
doing business in accordance with the master contract. The Board's authority to assess must be renewed at the annual meeting in 1977 if it is not invoked earlier. The House of Delegates also authorized an additional assessment of \$500 for each member seeking coverage. The mandatory assessment of \$500 on active members will be prorated for the various membership classifications, and new bylaws language spells out that Society membership will be terminated if the assessment is not paid when due.

NEW OFFICERS ASSUME DUTIES William J. Kelly, M.D., Pittsburgh internist, was sworn in as president during the 1976 Annual Session. John V. Blady, M.D., Philadelphia surgeon, moved up to president elect; and John B. Lovette, M.D., Johnstown, also a surgeon, was elected vice president. Dr. Lovette had served as speaker of the House of Delegates, and was succeeded in this post by D. Ernest Witt, M.D., of Bloomsburg, who had been vice speaker. Donald E. Harrop, M.D., of Phoenixville, was elected vice speaker; and G. Winfield Yarnall, M.D., of Harrisburg, was re-elected secretary. Delegates also re-elected three trustees: Leroy A. Gehris, M.D., Reading, Second Councilor District; David J. Keck, M.D., Erie, Eighth Councilor District; and William C. Ryan, M.D., Somerset, Eleventh Councilor District. Charles K. Rose, M.D., of Allentown, and William A. Limberger, M.D., of West Chester, were chosen for the Judicial Council. AMA delegates whose terms begin January 1, 1977 are: R. William Alexander, M.D., Reading; Raymond C. Grandon, M.D., Harrisburg; William J. Kelly, M.D., Pittsburgh; William Y. Rial, M.D., Swarthmore; and George A. Rowland, M.D., of Millville. Alternate AMA delegates are: Donald C. Brown, M.D., of Irwin; Betty L. Cottle, M.D., Altoona; James B. Donaldson, M.D., Philadelphia; Michael P. Levis, M.D., Pittsburgh; and R. Robert Tyson, M.D., Philadelphia. John G. Hallisey, M.D., of Aliquippa, and David P. Morrison, M.D., of Doylestown, were elected to the Committee to Nominate Delegates and Alternates to the AMA. The Board of Trustees re-elected Dr. Rowland as chairman and Dr. Ryan as vice chairman.

DELEGATES SET FUTURE POLICY With a virtually normal attendance, despite "the Pennsylvania incident" and its link by the news media with the Bellevue-Stratford, the House of Delegates set future policy with the following actions: Rescinded a 1974 policy prohibiting further funding of the Pennsylvania Medical Cooperative and authorized financial aid in the form of loans in an amount to be determined by the Board of Trustees; Deferred action on unified membership with the AMA until the 1977 Annual Session; Reaffirmed the Society's position on abortion, thereby rejecting three resolutions calling for government restriction or constitutional ban. The House by unanimous vote amended the Society's bylaws by providing for expulsion from membership of unqualified physicians testifying as expert witnesses in court cases. This is the adopted definition: "Expert witness must have basic educational and professional knowledge as a general foundation for his testimony, and in addition, have current personal experience and practical familiarity with the problems that are being considered and be actively engaged in the practice of the medical subject under discussion." The House also called on the Council on Medical Service to continue its surveillance of Blue Shield and examination of the effect of one statewide level of payment as called for in a 1975 resolution. Dues for active members remain at \$150 for 1977.

MOST MEET SOCIETY'S EDUCATION REQUIREMENT The Council on Education and Science reported to the House of Delegates that 93 percent of the Society's membership had met the Society's education requirement as of September 13, 1976. With reports of educational activities fulfilling the requirement due at the end of 1976, the Council will issue individual status reports to those who have not indicated compliance by October 15, 1976.

Pennsylvania Medicine



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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow

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RECENT CHANGES

federal register

**Providing
Drug Information
to Physicians**

**Informational
Bulletin #433-76**

**National
Health
Insurance**

special report
**Malpractice
insurance:**

**drug
bulletin**

**Health care doesn't
need more red tape**

**Drug firms challenge
'MAC' rules**

**Drug
Substitution**

**The Consensus Determinator
of Health Progress**
RESEARCH

Mailgram

A man with a mustache, wearing a white hard hat and a dark blue work shirt, is shown from the chest up. He has a white medical sling supporting his right arm. He is holding a dark, rounded object, possibly a helmet, in his left hand. The background is dark and industrial, with a sign that says "DISPENSARY" visible on the left. The lighting is dramatic, highlighting the man's face and the texture of his clothing.

Tough...

(even when
pain calls
for codeine)

but he may not have the stomach for APC.

Or the kidneys, for that matter. Even bleeding time and platelet aggregation can be maximally prolonged by a single aspirin tablet.*

We took that into account in revising the formula of Phenaphen® with Codeine, and combined codeine (in any of three different strengths) with acetaminophen to complement the codeine with little risk of APC complications. While there's no anti-inflammatory activity, there's no aspirin to aggravate G.I. problems or adversely affect bleeding time. Similarly, there's no potential renal risk from phenacetin, and no caffeine to stimulate patients unnecessarily.

There is the convenience of telephone Rx under Federal law...and the complementary analgesic efficacy of acetaminophen.

Phenaphen® with Codeine. Not just for patients who might have a "compound" problem, but for almost every patient who needs codeine. It's a lot simpler than APC.

BRIEF SUMMARY

Contraindications: Hypersensitivity to acetaminophen or codeine.

Warnings: *Drug dependence.* Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with same caution appropriate to oral narcotics. Subject to the Federal Controlled Substances Act.

Usage in ambulatory patients. Caution patients that acetaminophen and codeine may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery.

Interaction with other CNS depressants. Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) may exhibit additive CNS depression; when used together reduce dose of one or both.

Usage in Pregnancy. Safe use is not established. Should not be used in pregnant patients unless potential benefits outweigh possible hazards.

Precautions: *Head injury and increased intracranial pressure.* Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal condition. Acetaminophen and codeine or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

Special risk patients. Administer with caution to elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, or prostatic hypertrophy or urethral stricture.

Adverse Reactions: Most frequent are lightheadedness, dizziness, nausea, and vomiting; more prominent in ambulatory than in nonambulatory patients; some may be alleviated if patient lies down; other: euphoria, dysphoria, constipation and pruritus.

Drug Interactions: CNS depressant effect may be additive with that of other CNS depressants. See Warnings.

For symptoms and treatment of overdosage and full prescribing information, see package insert.



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to complement codeine with little risk of APC complications

*Mielke, C.H., et al. JAMA
235:613 (Feb. 9) 1976.

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Dr. Lyons elected chairman of state medical board

Richard C. Lyons, M.D., Erie urologist, was named chairman of the State Board of Medical Education and Licensure at the board meeting September 1-3, in Harrisburg. Philip E. Ingaglio, M.D., Philadelphia, a family physician, was elected vice chairman. Dr. Lyons succeeds William J. Kelly, M.D., of Pittsburgh, as chairman.

Born in Corry, Pennsylvania, Dr. Lyons received his degree in medicine from the University of

Pittsburgh School of Medicine in 1944. He interned at the Federal Security Agency Hospital in Washington, D.C. and received his residency training in urology at the Mayo Clinic. He was certified by the American Board of Urology in 1955.

He is chairman of the department of urology at Hamot Hospital in Erie and has served in the House of Delegates of the Pennsylvania Medical Society and as president of the Northwest Penn-

ing educational sessions, and reporting evaluation findings.

Potential surveyors must be currently licensed physicians, have a broad based clinical background, and have performed top level hospital and staff functions.

Physicians interested in applying for the surveyor position or seeking further information may contact: Surveyor Procurement Office, Joint Commission on Accreditation of Hospitals, 875 North Michigan Ave., Chicago, IL 60611; (312) 642-6061.

sylvania Chapter of the American College of Surgeons.

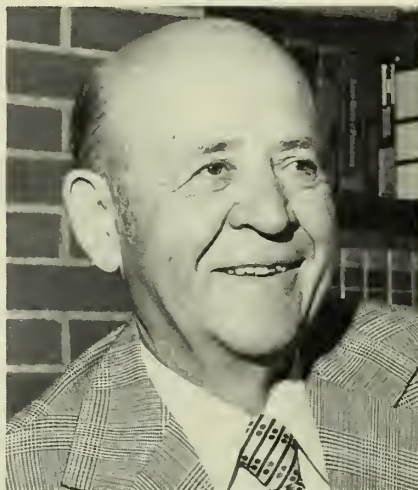
Preceptorships offered

"Preceptorships for Practicing Physicians," an individualized continuing medical education program, is being offered during the 1976-77 academic year by the Medical College of Pennsylvania.

The program is designed to give family practitioners and other specialists the opportunity to update present skills and learn new patient care techniques.

"Preceptorships for Practicing Physicians" has been approved for Category I credit toward the Physician's Recognition Award of the American Medical Association, hour for hour credit by the American Academy of Family Physicians, and 64 to 210 credit hours by the American College of General Practitioners.

For more information contact: Gerald H. Escovitz, M.D., Associate Dean for Medical Education, The Medical College of Pennsylvania, 3300 Henry Ave., Philadelphia, PA 19129; (215) 842-7118.



NEW OFFICERS of the Pennsylvania Medical Society as a result of action at the 1976 Session of the House of Delegates are, left to right: William J. Kelly, M.D., Pittsburgh, president; John V. Blady, M.D., Philadelphia, president elect; and John B. Lovette, M.D., Johnstown, vice president.

Interspecialty Committee restructured for '76-'77

During its August meeting the Society Board of Trustees and Councilors confirmed Interspecialty Committee members and alternates appointed by William J. Kelly, M.D., Society president. The members and alternates are as follows:

Allergy—Martin A. Murcek, M.D., Westmoreland County, member; Gilbert A. Friday, M.D., Allegheny County, alternate.

Anesthesiology—Louis J. Hampton, M.D., York County, member; David J. Torpey, M.D., Allegheny County, alternate.

Colon and Rectal Surgery—Howard D. Trimpi, M.D., Lehigh County, member; Indru Khubchandani, M.D., Lehigh County, alternate.

Dermatology—Herbert M. Parnes, M.D., Dauphin County, member; Joseph H. Gerdes, Jr., M.D., Dauphin County, alternate.

Family Physicians—John J. Hanlon, M.D., Cumberland County, member; Leroy A. Rodgers, M.D., Cambria County, alternate.

Internal Medicine—Robert S. Pressman, M.D., Philadelphia County, member; Alexander M. Minno, M.D., Allegheny County, alternate.

Clinical Pathology—Rosario Maniglia, M.D., Dauphin County, member; James M. Smith, M.D., Cumberland County, alternate.

Pediatrics—James E. Jones, M.D., Dauphin County, member; Ray G. Sarver, M.D., Westmoreland County, alternate.

Physical Medicine and Rehabilitation—Vacant.

Plastic Surgery—Thomas J. Nauss, M.D., Luzerne County, member; Harvey W. Austin, M.D., Allegheny County, alternate.

Psychiatry—Rex A. Pittenger, M.D., Allegheny County, member; Edward C. Leonard, Jr., M.D.,

Philadelphia County, alternate.

Radiology—C. Jules Rominger, M.D., Philadelphia County, member; Ross H. Smith, Jr., M.D., Philadelphia County, alternate.

Surgery—Robert A. Buyers, M.D., Montgomery County, member; Alfred S. Frobese, M.D., Philadelphia County, alternate.

Thoracic Surgery—Joseph C. Donnelly, Jr., M.D., Philadelphia County, member; Robert G. Pontius, M.D., Allegheny County, alternate.

Urology—Robert H. Clymer, M.D., Berks County, member; Joseph T. Marconis, M.D., Schuylkill County, alternate.

Neurosurgery—Henry H. Hood, M.D., Montour County, member; James P. Argires, M.D., Lancaster County, alternate.

Nuclear Medicine—Gilbert H. Isaacs, M.D., Allegheny County, member; David R. Brill, M.D., Montour County, alternate.

Obstetrics and Gynecology—Leopold Loewenberg, M.D., Philadelphia County, member; James S. Bates, M.D., Montour County, alternate.

Ophthalmology—George Gerneth, M.D., Allegheny County, member; Turgut N. Hamdi, M.D., Philadelphia County, alternate.

Otolaryngology and Maxillofacial Surgery—Eugene B. Rex, M.D., Montgomery County, member; James M. Cole, M.D., Montour County, alternate.

Orthopaedic—Robert H. Cram, M.D., Philadelphia County, member; Willard H. Love, Jr., M.D., Dauphin County, alternate.

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* *Selected Topics in Internal Medicine*, March 2-4, 1977. University of West Virginia, Morgantown, W.Va. Director: Edmund B. Flink, M.D., F.A.C.P.

* *Selected Topics in Internal Medicine*, April 14-16, 1977. Washington Hospital Center, Washington, D.C. Director: James A. Curtin, M.D., F.A.C.P.

* *Update in Infectious Diseases*, April 27-29, 1977. The Medical College of Pennsylvania, Philadelphia, Pa. Director: Donald Kaye, M.D., F.A.C.P.; Co-Director: Matthew E. Levison, M.D., F.A.C.P.

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Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
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Final classification of the less-than-effective indications requires further investigation.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium® (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacologic effects of agents, particularly potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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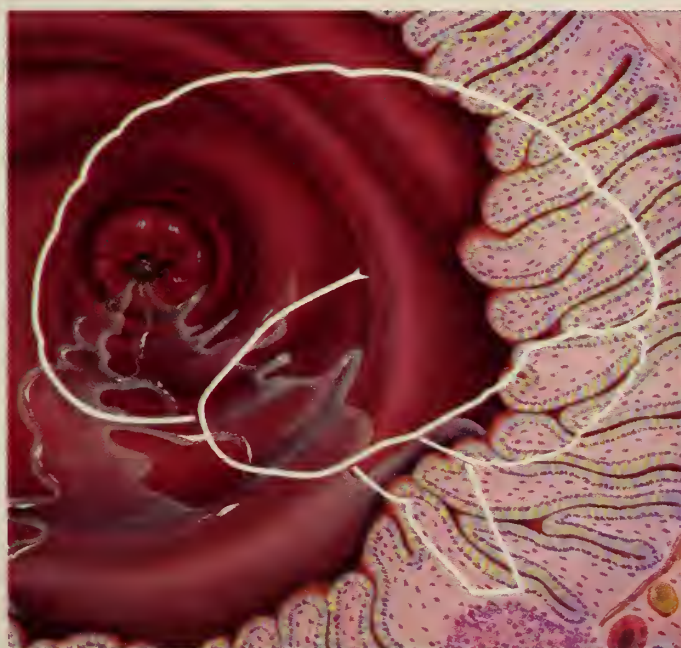
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Medical Arts '76 features program variety

The Pennsylvania Medical Society Council on Education and Science will sponsor Medical Arts '76, a series of continuing medical education seminars, Wednesday, November 3, to Friday, November 5, at the Hershey Motor Lodge and Convention Center, Hershey. Medical Arts '76 will include segments on regulatory agencies, psychiatry, colon and rectal surgery, orthopedic surgery, plastic surgery, and office management.

Regulatory agencies

The Pennsylvania Council of Health Professionals will present the "Role and Impact of Regulatory Agencies on Health Care Delivery" November 3 from 8:30 a.m. to 3:00 p.m. The program's objectives are to examine the number, scope, and effectiveness of governmental regulations on health professionals, explore the impact of regulatory boards on patient care, consider future directions of licensure standards, and improve communications skills among health professionals.

Program segments will include: "Should Health Professionals Be Regulated?" by Edward W. Robinson, Jr., commissioner of Professional and Occupational Affairs; "Medical Board's Control of Health Professions—Stimulant or Deterrent?" by Richard C. Lyons, M.D., chairman of the State Board of Medical Education and Licensure; "Impact of Institutional Regulations on Health Professions," by Richard Zarin, director of the Division of Licensure in the Department of Health; "Is Public Protection Keeping Pace with Technological Innovations?" by Thomas M. Gerusky, director of the Bureau of Radiological Health in the Department of Environmental Resources; "Control

of Devices: Public Protection and Professional Responsibility," by Jack B. Ogun, chief of the Drug, Device, and Cosmetic Compliance Section in the Department of Health; and "How to Ask the Right Questions," by Robert L. Lamb, director of the communications division of the Pennsylvania Medical Society.

The registration fee is \$5.00 for members of the Council of Health Professionals and \$7.50 for non-members. Information on CME credit will be available at the time of the seminar.

Colon and rectal surgery

"Personal Methods in Colon and Rectal Surgery" will be presented November 3, 10:00 a.m. to 4:00 p.m., by the Pennsylvania Society of Colon and Rectal Surgery.

Among the speakers will be Philip Ferry, M.D., Kingston; Indru Khubchandani, M.D., Allentown; Joseph Prorok, M.D., Allentown; Paul Waltz, M.D., Harrisburg; Joseph Quill, M.D., Norristown; William Davy Smith, M.D., Chester; John Connolly, Jr., M.D., Langhorne; Henry Schneider, M.D., Abington; Jacob Benson, M.D., Philadelphia; Harold Rovner, M.D., Philadelphia; Frank Theuerkauf, M.D., Erie; Guy Kratzer, M.D., Allentown; and Gerald Marks, M.D., Philadelphia.

Some of the topics for discussion will be management of the irritable bowel syndrome, the fiber fad, colorectal endometrioma, colonic anastomosis, outpatient fistulectomy, local anesthesia for anorectal surgery, medical legal considerations in proctology, and transsacral repair of rectal prolapse.

The program has been approved for hour for hour credit in Category I for the Physician's Recognition Award of the AMA.

No registration fee is required; luncheon is \$10. Reservations for lunch should be mailed directly to Gerald Marks, M.D., 255 S. 17th St., Philadelphia, PA 19103, along with a check for \$10 payable to the Pennsylvania Society of Colon and Rectal Surgery.

Medical education

Thursday's activities will begin with the annual meeting of the Pennsylvania Association for Medical Education 10:00 a.m. to 12:00 noon. On the agenda are a discussion on graduate training, state rules and regulations, conducted by Richard C. Lyons, M.D., and a discussion on decentralization of undergraduate medical education, by Wilbur W. Oaks, M.D., chairman of the department of medicine in Hahnemann Medical College and Hospital, followed by a business session.

Holography

From 1:00 p.m. to 5:00 p.m. the Pennsylvania Medical Society will sponsor a program, "Laser Holography and Its Application to Medical Science." The program will describe to physician medical educators the applications of holography as a diagnostic tool and an educational technique. It is approved for 4 hours of Category I credit for the AMA's Physician's Recognition Award.

Office management

The Pennsylvania Society, American Association of Medical Assistants, Inc., will sponsor a seminar on office management 8:30 a.m. to 4:30 p.m. Friday.

Presenting the seminar will be Leif C. Beck, LL.B., and Vasilios J. Kalogredis, J.D., of Management Consulting for Professionals, Bala Cynwyd, and Karen Zupko, program director in the AMA Department of Practice Management. Participants will first hear an overview of management prac-

tices and communication, then may choose to attend one of three sessions: "Talking with Patients: Use of the Telephone," "Techniques of Being an Office Manager," or "Business Operations, Billing and Record Keeping, Insurance, Collection."

Registration fee is \$15. for members of Pennsylvania Society, American Association of Medical Assistants, \$20 for non-members, and \$10 for students. No registration will be accepted or fees returned after October 29.

Orthopedics

The scientific program of the Pennsylvania Orthopaedic Society will be presented Friday 8:45 a.m. to 4:00 p.m. Some of the segments will be: "Etiology and Prevention of Neck Injuries in Tackle Football," by Joseph S. Torg, M.D., director of Temple University's Center for Sports Medicine; "Diagnosis and Management of Stress Fractures in Athletes," by Mary W. Clark, M.D., assistant professor of orthopedic surgery at Pitt; "Management of Chronic Pain in Orthopedic Patients," by Edward Resnick, M.D., associate professor of orthopedic surgery at Temple's Health Sciences Center; "A Practical Scoliosis Screening Program for Pennsylvania Schools," by Ned Schwentker, M.D., associate professor of orthopedic surgery at the M.S. Hershey Medical Center; "Orthopaedic Manpower Study and Its Implications for the Commonwealth," by Robert B. Greer, III, M.D., professor and chief of orthopaedic surgery at Hershey; "Diaphyseal Radial and Ulna Fractures Treated by Compression Plating," by Robert Simon Mathews, M.D., clinical associate professor of orthopaedic surgery at Hershey; "Use of Total Hip Replacement in Patients with Paget's Disease," by Edward McClain, M.D., clinical associate professor of orthopaedic surgery at Pitt; and "Surgical Repair of

Springle's Deformity," by William R. Green, Jr., M.D., associate professor of orthopaedic surgery at Pitt.

The program is approved by the AMA for 5 Category I credits. No fee is required.

Plastic surgery

The Robert H. Ivy Society will present its scientific program Friday 2:00 p.m. to 4:00 p.m. Panel discussions on rhinoplasty and cleft lip and palate will be included. No fee is required. For more information on the program contact Donald N. McCoy, 20 Erford Rd., Lemoyne, PA 17043.

Psychiatry

An "Update on Major Issues Before Pennsylvania Psychiatrists," the fall program of the Pennsylvania Psychiatric Society (PPS), will be held Friday, beginning during lunch and ending at 5:00 p.m. Included in the program will be individual presentations on items such as PaMPAC; changes in the mental health system; Mental Health Procedures Act and commitment and Health Service Areas by physicians, legislators, and government officials and staff; panel discussion; and group responses and questions. The meeting is acceptable for Category I credit.

PPS members will receive program information. Others may contact Donald N. McCoy, PPS Executive Secretary, 20 Erford Rd., Lemoyne, PA 17043.

Surgeons to study

On Thursday, November 4, at 1:30 p.m., the Central Pennsylvania Chapter of the American College of Surgeons will present a program on anticoagulants, antibiotics, and chemotherapy. Lewis T. Patterson, M.D., of Harrisburg, will preside at the session which carries three hours of Category One credit. There is no fee.

Other activities

Following are other functions which will be held during Medical Arts '76:

Council meeting of the Pennsylvania Society of Colon and Rectal Surgery, Tuesday, November 2, 9:00 p.m. to 10:00 p.m.

Executive Committee meeting of the Council on Education and Science of the Pennsylvania Medical Society, November 3, 1:00 p.m.

Business meeting of the Pennsylvania Academy of Ophthalmology and Otolaryngology, 2:00 p.m. to 4:00 p.m., followed by a council meeting and dinner, 4:00 p.m. to 6:30 p.m.

Executive Committee meeting of the Pennsylvania Orthopaedic Society, November 4, 4:00 p.m. to 6:00 p.m., followed by cocktails at 6:30 p.m. and dinner at 7:30 p.m.

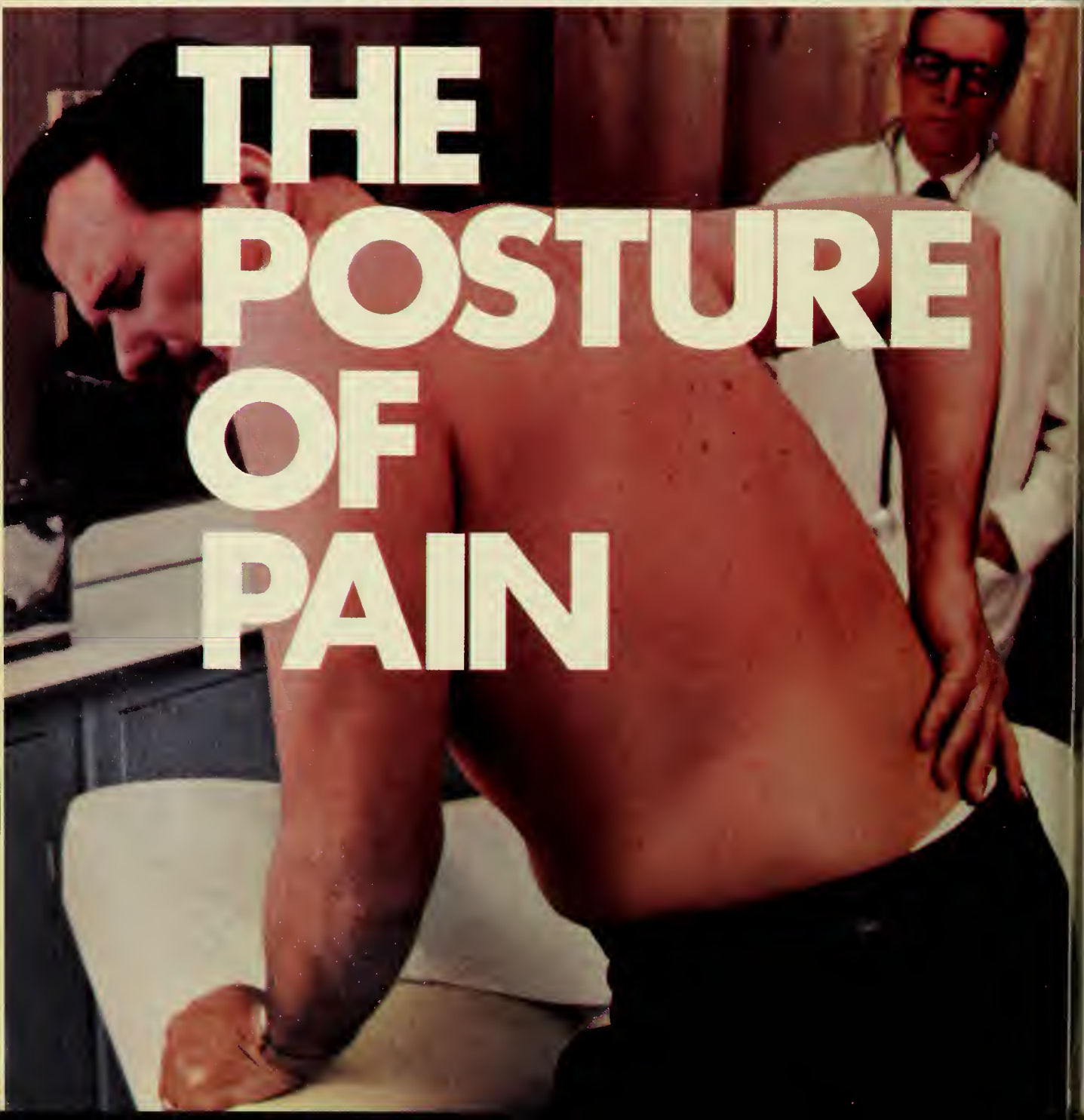
American College of Radiology Socioeconomic Workshop, November 5, 9:00 a.m. to 5:00 p.m.

Council Meeting of the Pennsylvania Psychiatric Society, November 5, 9:30 a.m. to noon.

Finance Committee and Board Meeting of the Pennsylvania Radiological Society, November 5, 10:00 a.m. to 4:00 p.m.

For information about any of the programs in Medical Arts '76 contact the Society's Council on Education and Science, 20 Erford Rd., Lemoyne, PA 17043; (717) 238-1635.

The Department of Health has adopted new rules adding to the list of controlled substances, thereby putting state law in conformity with federal law, and permitting physicians to disperse among other pharmaceuticals those drugs on Schedules II, III, IV, and V of the Schedule of Controlled Substances. Earlier regulations required that Schedule II substances be stored in securely locked cabinets. The new listing includes phendimetrazine, amobarbital, chlor-diazepoxide, diazepam, phen-termine, and similar preparations.





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Warnings: *Idiosyncratic Reactions:* Rarely, extreme weakness, transient quadriplegia, dizziness, ataxia, temporary vision loss, diplopia, mydriasis, dysarthria, agitation, euphoria, confusion and disorientation have appeared within minutes or hours of the first dose. These usually subside in several hours but supportive and symptomatic therapy, including hospitalization, may be necessary.

Pregnancy and Lactation: Safe use not established; weigh potential benefits against potential hazards in pregnancy, nursing mothers (concentrations in breast milk are two to four times that in plasma), or women of childbearing potential.

Children Under Twelve: Not recommended.

Potentially Hazardous Tasks: Driving a motor vehicle or operating machinery.

Additive Effects: Effects of carisoprodol and alcohol, other CNS depressants or psychotropic drugs may be additive.

Drug Dependence: Use cautiously in addiction-prone patients.

Precautions: To avoid excess accumulation, use caution in patients with compromised liver or kidney function.

Adverse Reactions: *Central Nervous System:* Drowsiness, dizziness, vertigo, ataxia, tremor, agitation, irritability, headache, depressive reactions, syncope, insomnia, idiosyncratic reaction (see "Warnings").

Allergic or Idiosyncratic: In previously unexposed patients, these are usually seen after 1-4 doses and include rash, erythema multiforme, pruritus, eosinophilia, fixed drug eruption with cross reaction to meprobamate. Asthmatic episodes, fever, weakness, dizziness, angioneurotic edema, smarting eyes, hypotension and anaphylactoid shock may be manifestations of severe reactions. In such cases, stop carisoprodol and initiate appropriate treatment (e.g., epinephrine, antihistamines, corticosteroids).

Cardiovascular: Tachycardia, postural hypotension, facial flushing.

Gastrointestinal: Nausea, vomiting, hiccup, epigastric distress.

Hematologic: Leukopenia and pancytopenia (on carisoprodol plus other drugs).

Usual Adult Dosage: One 350 mg tablet three times daily and at bedtime.

Overdosage: Has produced stupor, coma, shock, respiratory depression, and, very rarely, death. The effects of an overdosage of carisoprodol and alcohol or other CNS depressants or psychotropic agents can be additive even when one of the drugs has been taken in the usual recommended dosage. Empty stomach, treat symptomatically; cautiously give respiratory assistance, CNS stimulants, pressor agents as needed. Carisoprodol is metabolized in the liver and excreted by the kidney. Diuresis and dialysis have been used successfully with related drug meprobamate. Carefully monitor urinary output; avoid overhydration; observe for possible relapse due to incomplete gastric emptying and delayed absorption.

Before prescribing, consult package circular or latest PDR information.

1. Hindle, T.H. III. *Calif. Med.* 117:7 (Aug.) 1972. 2,3. Unpublished Data on file, Medical Department, Wallace Laboratories, Cranbury, N.J.

HEW to enforce rules on laboratory charges

In a series of letters to state medical societies, the Department of Health Education, and Welfare (HEW) has announced its crackdown on abuses in the medicare laboratory program. On May 4, Thomas M. Tierney, director of the Bureau of Health Insurance, warned that rebates from independent laboratories violate the Medicare law (42 United States Code 1395nn (b)).

"Whoever furnishes items or services to an individual for which payment is made or may be made under this subchapter and who solicits, offers, or receives any (1) kickback or bribe in connection with the furnishing of such items or services or the making or receipt of such payment, or (2) rebate of any fee or charge for referring any such individual to another person for the furnishing of such items or services, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$10,000 or imprisoned for not more than one year, or both."

HEW is urging all physicians to report offers of kickbacks from independent labs for investigation and prosecution. The Bureau of Health Insurance regional representative for Pennsylvania who should be contacted is Maurice Hartman, P.O. Box 8788, Philadelphia, Pennsylvania. The telephone number is (215) 596-6826.

Such "rebates" from labs are also prohibited under the rules and regulations of the Pennsylvania Department of Health. Regulations for Pennsylvania's Clinical Laboratory Act specifically prohibit "rebates" or other types of "fee splitting inducements." Blanket fee contracts are prohibited. Volume discounts may be given but the fee schedule must clearly indicate them and they

must be offered to all clients. Except for volume discounts "only a single fee schedule shall be maintained and applied by a licensed laboratory."

On July 28 HEW notified the State Society that it will begin strict enforcement of regulations against "padding" laboratory charges. Medicare regulations require that the charge for a laboratory test, performed by an independent laboratory but billed by the attending physician, "be related to the cost the physician incurred in obtaining the service for his patient." HEW says it will permit "as reasonable a nominal charge by the physician for the drawing of specimens and handling expenses" but *nominal* is not defined. However, what HEW terms a "physician markup" will not be permitted. Nor will HEW use medicare dollars to pay non-medicare certified labs. The government says it must know the source of lab services and be as-

sured that a medicare approved lab was used if the service is to be reimbursed.

So called "kiting" or "padding" is also addressed by Pennsylvania law. Section 5.48 of the Commonwealth's laboratory regulations requires:

"The notification of all charges for laboratory tests performed for the patient must be sent to the patient by the clinical laboratory unless the patient has been billed directly or otherwise notified of such charges by said laboratory."

PMS is on record with the health department as being opposed to the "disclosure" provision as a threat to patient-physician confidentiality. According to the AMA it is preferable for a clinical laboratory, rather than a physician, to bill a patient for the laboratory's services. The AMA also says that an attending physician is entitled to "fair compensation for the professional services he renders."

Jefferson starts Ragarathnam fund

Thomas Jefferson University has established a legal defense fund to help C. S. Rangarathnam, M.D., defray the legal costs resulting from criminal charges which were brought against him and of which he was subsequently acquitted.

The costs accumulated during Dr. Rangarathnam's trial totalled \$50,000. The Philadelphia Academy of Surgery, the State Society, the Philadelphia County Medical Society, and members of the department of surgery of Jefferson Medical College have already contributed to the fund. In spite of the contributions already made, \$24,000 remain to be paid.

Contributions to the Rangarathnam Defense Fund may be sent to Rangarathnam Defense Fund, c/o Francis O'Brien, Con-

troller, Thomas Jefferson University, 11th and Walnut Sts., Philadelphia, PA 19107.

PNA offers insurance plan

The Pennsylvania Nurses Association has offered its liability insurance plan to the 2,777 Pennsylvania nurses holding policies with the Royal-Globe Insurance Company, which recently announced plans to pull out of the malpractice insurance market nationwide. Royal-Globe plans to stop writing liability insurance July 1, 1977.

The association's comprehensive professional and personal liability plan currently carries 4,100 nurses in the state. The plan is available to any nurse who holds a private insurance policy and feels insecure with her present plan.

Society's 1976 loans aid 146 medical students

According to the annual report of the Society's Educational and Scientific Trust, the Committee on Aid to Education in August granted a total of \$186,650 in loans to 146 medical students. Loans totaling \$76,350 were granted to 51 fourth year students, and 95 third, second, and first year students received a total of \$110,300.

All of Pennsylvania's seven medical schools have again increased tuition for the 1976-77 school year. The three state related schools—the University of Pittsburgh, the Pennsylvania State University, and Temple University—have set tuition at \$3,000; Jefferson Medical College charges \$4,600; the Medical College of Pennsylvania and the University of Pennsylvania charge \$5,000; and Hahnemann Medical College charges \$5,300.

Increases in tuition and other expenses of attending medical school are evident in the amounts medical students owe when they graduate. Seventy borrowers graduating in the class of 1976

owed a total of \$203,450 to the Trust. The loans granted the students by the Trust amount to only about 20 percent of the total debts. Of the 70 graduates, 19 owed 51 percent of the total and had individual debts to the Trust of \$4,000 to \$10,500, which means that their total debts at graduation ranged from \$20,000 to \$40,000.

Federal legislation, currently in conference committee, provides for additional loan funds and ser-

vice commitment grants for medical students, but proposes to raise the interest rate on loan funds from the current 3 percent to 7 percent. If the legislation becomes law, the present 4 percent rate on loans from the Trust may have to be increased to at least 6 percent.

The total assets of the Trust on December 31, 1975, reached \$1,868,549, of which \$1,552,998 is invested in loans to a total of 899 borrowers.

Geisinger changes governing structure

The board of directors of Geisinger Medical Center, Danville, at their recent annual meeting voted to adopt a corporate structure and establish a board of governors. The move was made in an effort to cope with the growing size and complexity of the institution.

Corporate officers under the new structure are: Henry Hood, M.D., president and chairman of the board of governors; Harry C. Stamey, M.D., senior vice president and medical director; and F. Kenneth Ackerman, Jr., senior vice president and administrative director.

Ellsworth Browneller, M.D.,

was appointed to the newly created position of vice president and director of public programs. Dr. Browneller, a former state secretary of health, will maintain liaison with local, state, and federal government. In addition he will continue in his current position as administrator of the Health Services Research and Development Center at Geisinger.

William Gibson, M.D., associate in the department of otolaryngology, was named assistant to the president, and Kenneth Quickel, M.D., associate in the department of endocrinology and metabolism, was named assistant to the medical director.

New insurance available to residents

The National Association of Residents and Interns (NARI) has made available a new malpractice insurance plan for interns, residents, fellows, and physicians in the military in most states. The Glacier General Assurance Company of Missoula, Montana, is the underwriter of the plan.

A point of special interest in the plan is the occurrence provision which states that a doctor who discontinues the plan will still be covered against acts of malpractice that occurred when the policy was in effect.

Coverage under the NARI/Glacier plan is available for \$100,000/\$300,000, \$200,000/\$600,000, or \$1,000,000/\$1,000,000 of protection covering activities both in and out of an intern's or resident's training hospital.

Physicians who are not members of NARI may participate in the plan by applying for membership through Physicians Planning Service representatives in most principal cities or by mail to the association at 292 Madison Ave., New York, NY 10017.

Philadelphia dispute ends

Blue Cross of Greater Philadelphia and the Delaware Valley Hospital Council (DVHC), representing 32 nonprofit hospitals, have reached agreement on the terms of a three year contract, concluding a dispute begun in 1973 that at times threatened ready access to medical care services for 2.4 million Philadelphia area residents.

When Blue Cross and DVHC had not reached an agreement by 1975, the Legislature passed Act 94, empowering the insurance commissioner to conduct fact finding sessions and issue guidelines for negotiating sessions, through which the dispute was concluded.

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INDICATIONS For the prophylaxis and long term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset of action is somewhat slower than that of nitroglycerin.

PRECAUTIONS As with other effective nitrates, some fall in blood pressure may occur with large doses.

Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilatation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

SIDE EFFECTS No serious side effects have been reported. In sublingual therapy a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrites, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustment of the cerebral hemodynamics to the initial marked cerebral vasodilatation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

SUPPLIED 10 mg chewable tablets, bottle of 100. Also 5, 10 and 15 mg scored tablets in bottles of 100. 10 mg scored tablets also supplied in bottle of 1,000.

Also available Cardilate® P brand Erythrityl Tetranitrate with Phenobarbital* (*Warning: may be habit-forming)

1. Russek HJ: AM J M Sc 239:478, 1960



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Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Powdered opium, USP	24.0 mg.
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(warning: may be habit forming)	
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(preservative)	
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Hydrobromide, NF 10 mg
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For many years Robins has spotlighted the expectorant action of the Robitussin cough formulations by featuring action photographs of steam engines like the one on the preceding page. In keeping with this tradition, last year the company commissioned a well-known illustrator to render full-color drawings of several classic locomotives . . . accurate to the minutest detail. Chances are you requested and received the first locomotive in this series, The William Mason, last winter. Now, the second one is available. (See below). To order your print suitable for framing, write "Robitussin Clear-Tract Engine #2" on your Rx pad and mail to "Vintage Locomotives," Dept. T4, A. H. Robins Company, 1407 Cummings Drive, Richmond, Va. 23220.



UR PHOTO: Norfolk & Western Branch Train
3, 202 west bound near Alvarado, Va. (Oct., 1956).
his line reaches the highest point of any railroad
ist of the Rockies (elevation 3,577 ft.) with a
imum grade of 3%. It crosses 108 bridges,
me 700 ft. long! Photo by O. Winston Link.

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MANAGEMENT OF THE ACUTE CRITICALLY ILL PATIENT

Jeanes Hospital, Fox Chase,

Philadelphia 19111

Wednesday, November 17, 1976

8:00-8:10 a.m. Registration

and Pharmacology, University of Pittsburgh School of Medicine, Pittsburgh

8:10-8:20 a.m. **Introduction**—Joseph M. Winston, M.D., Director of Medical Education, Jeanes Hospital
Welcome to Jeanes Hospital—Roger W. Hallowell, President, Board of Trustees, Jeanes Hospital
Moderator—Robert A. Donato, M.D., Medical Director, Jeanes Hospital

11:55-12:10 p.m. Questions

12:15-1:15 p.m. Lunch

8:20-9:10 a.m. **"New Approaches to the Severely Traumatized Patient"**—David Wagner, M.D., Associate Professor of Surgery, Hospital of the Medical College of Pennsylvania, Philadelphia

1:15-2:05 p.m. **Annual Memorial Lectureship Introduction**—Nathan P. Salner, M.D., President of Medical Staff, Jeanes Hospital

9:10-10:00 a.m. **"Electrocardiogram as a Diagnostic Tool"**—John H. Stone, M.D., Associate Professor of Medicine, Director of Emergency Medicine, Emory University School of Medicine, Atlanta, Georgia

"Sudden Death—Drugs and Defibrillation"—John H. Stone, M.D., Associate Professor of Medicine, Director of Emergency Medicine, Emory University School of Medicine, Atlanta, Georgia

10:00-10:15 a.m. Coffee Break

2:05-2:55 p.m. **"Management of the Comatose Patient"**—Jerome B. Posner, M.D., Professor of Neurology, Cornell University Medical College and Chief of Neurology, Memorial Hospital, New York, N.Y.

10:15-11:05 a.m. **"Oxygen Transport in the Critically Ill"**—James Snyder, M.D., Assistant Professor of Anesthesia and Critical Care Medicine, University of Pittsburgh School of Medicine, Pittsburgh

2:55-3:45 p.m. **"Management of Severely Ill Patients Suspected of Having Bacterial Meningitis, Gram-negative Sepsis, or Bacterial Pneumonia"**—Donald Kaye, M.D., Chairman, Department of Medicine, Hospital of the Medical College of Pennsylvania, Philadelphia

11:05-11:55 a.m. **"Clinical Pharmacology and Pharmacokinetics of Drugs in Acute Care"**—Robert H. McDonald, M.D., Associate Professor of Medicine

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WRITE FOR REPRINT: R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioğlu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric, *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25

(methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change, + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patient's vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Charles Swartz, M.D., was recently honored by the graduating class of Hahnemann Medical College and Hospital, with the Golden Apple Award for continued dedication and excellence in teaching. Dr. Swartz is professor of medicine, vice chairman of the department of medicine, and director of the division of nephrology and hypertension.

The 1976 graduating class of Jefferson Medical College, Thomas Jefferson University, recently presented a portrait of **Edward H. McGehee, M.D.**, to the college as a token of their respect for him as a teacher. Dr. McGehee is professor of family medicine at Jefferson.

The medical staff of Temple University Hospital recently presented a distinguished service award to **Emanuel M. Weinberger, M.D.**, "in recognition of outstanding service and dedication" to the hospital. Dr. Weinberger, assistant clinical professor of medicine, was the recent recipient of the Chapel of Four Chaplains Silver Anniversary Humanitarian Award.

William C. Stainback, M.D., Berwyn, was recently appointed coordinator of surgical education of hospitals affiliated with Jefferson Medical College. His responsibilities include standardizing the quality of surgical education at eleven Jefferson affiliated hospitals. Dr. Stainback is professor of surgery for Jefferson and director of the department of surgery for the Bryn Mawr Hospital.

On his recent retirement from Temple University School of Medicine, **Russell R. de Alvarez, M.D.**, was named emeritus professor of obstetrics and gynecology. Dr. de Alvarez joined Temple in 1964 as chairman of the department and in 1970 was named emeritus department chairman. Currently vice president of the American Gynecologic Society, he recently received an award from the American College of Obstetricians

Pennsylvania Hospital has dedicated a portrait of Victor C. Rambo, M.D., who for more than fifty years worked as a missionary, ophthalmologist, teacher, and researcher in India in an effort to rid the country of curable blindness. Sobha Singh, a well known artist in India, is shown above painting the portrait which now hangs in Pennsylvania Hospital. From 1923 to 1947 Dr. Rambo served in the mission hospital at Mungeli in rural central India and often performed dozens of eye operations in a single day. In 1947 he became a professor in the Christian Medical College, Vellore, South India. During his years there he was largely responsible for



training ophthalmologists and beginning mobile eye hospitals throughout the region. In 1957 Dr. Rambo became a professor in the Christian Medical College in Ludhiana, North India, where he worked the next 15 years. The Ex-Residents Association of Pennsylvania Hospital, where Dr. Rambo interned, in 1972 chose him to receive the Ehrenzeller Award for his work in India. In 1974 he returned to the United States in order to continue his efforts for the curable blind through The Rambo Committee, Inc., Philadelphia. The committee is working to obtain volunteers, equipment, and money because, as Dr. Rambo says, "We want every mission hospital in the world to have an eye doctor and department." The Rambo Committee is located at 6100 Greene Street (P. O. Box 4288), Philadelphia, PA 19144.

and Gynecologists for distinguished scientific contributions. Dr. de Alvarez is the only one of the 17,000 members of the college who has presented a paper at every annual meeting of the college during its 25 years of existence.

Richard S. Evans, M.D., director of Allegheny General Hospital's emergency department, was recently named president of the Emergency Medical Services Institute, Pittsburgh. The nonprofit agency coordinates emergency medical services in 12 southwestern Pennsylvania counties, and channels state and federal money through county emergency medical councils for the purpose of buying equipment and upgrading ambulance service.

Allentown Hospital's labor and delivery area in the department of obstetrics and gynecology was recently dedicated to **Anna M. Ziegler, M.D.**, at a special dinner held in her honor. A 1933 graduate of New York University School of Medicine, Dr. Ziegler is now semiretired as an obstetrician and gynecologist and spends much of her time as a prison counselor.

The Canonsburg General Hospital board of directors recently honored three physicians who have practiced medicine for a combined total of 155 years. **David Ingram, M.D.**, has been associated with the hospital 54 years; **Edward L. McCarthy, M.D.**, has practiced in the Pittsburgh area 51 years; **Michael Sharman, M.D.**, has practiced medicine for 50 years, first in Austria, then in the Canonsburg area.

Family and friends of **Fount B. Robinson, M.D.**, Oxford, recently gathered to honor him for his more than 41 years of service to the community. Dr. Robinson received a citation from the State Legislature and heard appreciative comments by some of his closest friends over the years.

John D. McCallum, M.D., Canton, was honored recently by the Bradford County Medical Society for 50 years in the practice of medicine. In presenting the State Society's fifty year award to Dr. McCallum, **Orlo G. McCoy, M.D.**, trustee of the Twelfth Councilor District, said, "The Bradford County Medical Society has had for a long time many outstanding doctors on its membership roster, and John McCallum is one of the exceptionally fine ones. . . ."

Donald L. Cohen, M.D., recently accepted the position of medical director for the medical technology program of the Community College of Beaver County, Monaca. He will serve additionally as adjunct professor of medical technology for the upcoming academic year. He is former director of laboratories at Sharon General Hospital.

Edward M. Sewell, M.D., was recently elected president of the American Lung Association of Philadelphia and Montgomery Counties. He is director of the division of respiratory diseases and co-director of the cystic fibrosis center, Children's Hospital of Philadelphia, and associate professor of pediatrics at the University of Pennsylvania School of Medicine.

Alvin F. Goldfarb, M.D., Bryn Mawr, was recently named medical coordinator of ambulatory gynecologic services for Pennsylvania Hospital and clinical professor of obstetrics and gynecology at the University of Pennsylvania School of Medicine. Dr. Goldfarb has served as secretary and president of the Philadelphia Endocrine Society and vice president of the Obstetrical Society of Philadelphia.

The Beaver County Medical Society recently honored **Thomas McCreary, M.D.**, a past president of the county and State Societies, for 50 years in the practice of medicine. Dr. McCreary, who is now retired from active practice, in 1929 opened Beaver County's first clinical pathology laboratory in the Rochester General Hospital. He is a founding member and past president of the Pennsylvania Association of Clinical Pathology.

Norman H. Gemmill, M.D., recently marked his fiftieth year in medical practice in Stewartstown. He is a past president of the York County Medical Society.

Daniel L. Newhall, M.D., Bala Cynwyd, was recently selected to participate in the National Endowment for the Humanities seminar on "Health Care Rights and Duties: Individuals, Society, and Medicine," to be held at the University of Texas Medical Branch in Galveston. Dr. Newhall is an emergency physician for the Delaware County Memorial Hospital, Drexel Hill.

A special recognition award was recently presented to **Roscoe W. Teahan, M.D.**, by the Montgomery Hospital for 30 years as director of the oncology clinic services at the hospital. The presentation was part of the program of the clinical skills day, a continuing education activity for the hospital's medical staff.

Samuel F. Cohen, M.D., was awarded an engraved silver plate for 30 years of membership in the Montgomery County Medical Society at the organization's 129th birthday celebration. Honored for 50 years in the medical profession was **M. Luther Kauffman, M.D.**, Jenkintown, who received the State Society's 50 year award. He has been a member of the Montgomery society since 1927.

Matthew M. Mansuy, M.D., president of the Lycoming County Medical Society, recently accepted an appointment as a clinical instructor in the Pennsylvania State University College of Medicine. He is on the faculty of Williamsport Hospital's family practice residency program.

The community of Muncy recently held a dinner in honor of **R. J. Patrizio, M.D.**, to express appreciation of his more than 30 years in medical practice there. The 400 guests had several surprises for Dr. Patrizio, including testimonial speeches, the presentation of a commemorative plaque, a new set of sails for his sail boat, and naming the Muncy swimming pool "Patrizio Pool."

The Janeway Medal of the American Radium Society was awarded to **Audrey E. Evans, M.D.**, during the group's recent meeting in Vancouver. Dr. Evans is director of oncology for The Children's Hospital of Philadelphia and current secretary treasurer of the American Association of Cancer Research.

Herbert Waxman, M.D., was recently named chief of medical services at Temple University Hospital. Dr. Waxman, who is professor of medicine in Temple's School of Medicine, is responsible for clinical training in medicine for students and residents at the university hospital. He was the 1973 recipient of Temple's Lindback Award for distinguished teaching.

Two physicians associated with the Hospital of the University of Pennsylvania recently addressed the national meeting of the American Federation of Clinical Research, held in Atlantic City. **David Lyon, M.D.**, Philadelphia, research fellow, discussed the "Relationship of Hepatic Bilirubin Excretion to Fasting and Feeding in Man." **Alan D. Schreiber, M.D.**, West Mt. Airy, hematologist and assistant professor of medicine, addressed the group on the topics of "Low Titer Cold Hemagglutinin Disease: Mechanism or Hemolysis and Response to High Dose Corticosteroids," and "Effect of C3b Inactivator on Macrophage Bound C3b Coated Erythrocytes."

Stanton Segal, M.D., was recently chosen physician of the year by the League of Children's Hospital of Philadelphia. Dr. Segal is professor of pediatrics and medicine for the University of Pennsylvania School of Medicine.

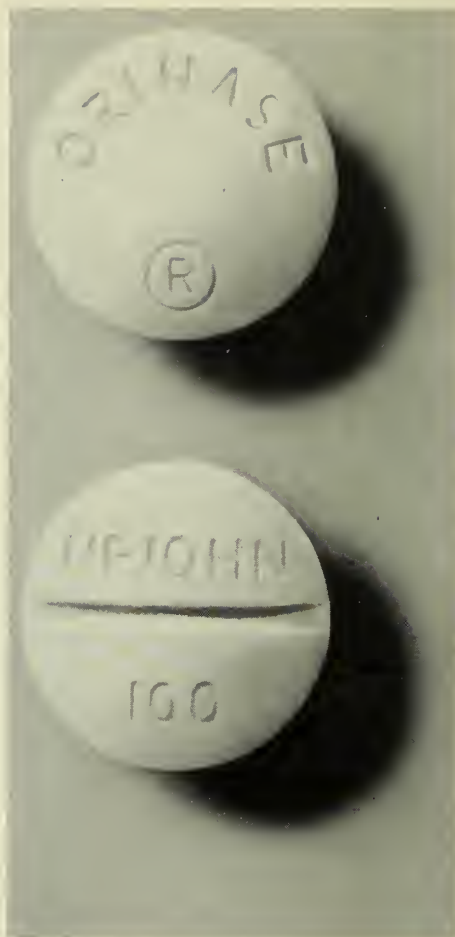
David E. Goldman, M.D., Wyndmoor, was recently named an emeritus professor at the Medical College of Pennsylvania. Until his retirement Dr. Goldman was director of graduate programs and professor of physiology and biophysics. He is the originator of the "Goldman Equation," providing information about salt concentrations inside and outside cells and voltage across cell membranes.

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Will history repeat itself?

Deja vu. We've been here before. The names are different and the party labels reversed, but the situation is similar.

Not since 1948 has an incumbent candidate in a presidential race faced what appear to be such overwhelming odds in an election. In Kansas City, the contest for the Republican nomination left Mr. Ford with a bare majority of the votes. The Ford-Reagan exercise prevented either candidate from centering his attention on the opposition party. The public opinion polls, both Harris and Gallup, seem to indicate that Governor Carter will win in November. However, since his nomination Ford has made some little gain.

Let us hope this year's campaign will be issue oriented. The party platforms are divergent enough to offer excellent points of debate. One of the major political topics will be the expanding governmental bureaucracy. The Carter campaign to date has been conservative to middle-of-the-road, centering on anti-big government. The platform is rather more liberal, a mandate for social action. It favors government involvement in wage and price decisions, overhaul of the tax system to ensure more equal distribution and federal administration of a system of income maintenance.

President Ford believes that the bureaucracy needs to be made more efficient. The Republican platform, perhaps reflecting Reagan's conservatism at least in part, appears to be in keeping with the aim of less government involvement. It opposes wage and price control, federalization of welfare, and guaranteed income. It favors an end to deficit spending and tax reform by reduction.

Whether either candidate can reorganize the entrenched bureaucracy remains to be seen. It will surely be a test of executive strength.

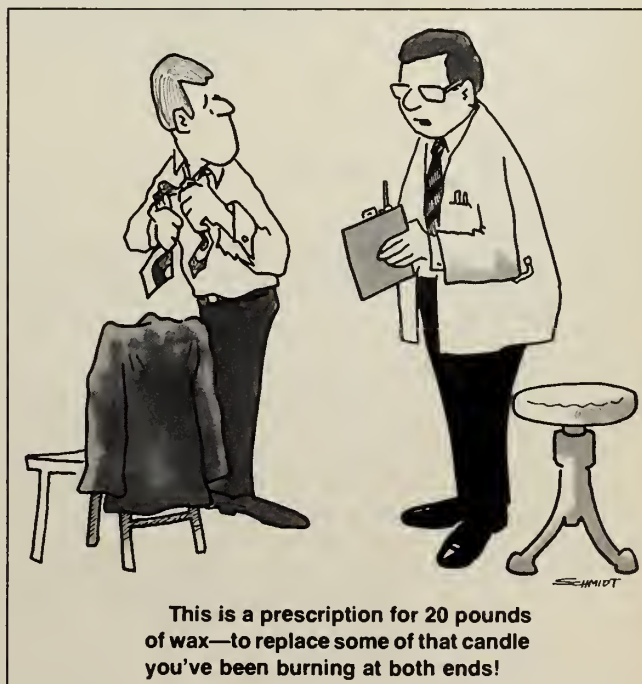
This year National Health Insurance (NHI) promises to be a campaign issue. Never before has NHI assumed so much importance in national politics. The Republican platform opposes compulsory NHI and favors some form of catastrophic illness protection utilizing the private health insurance system. It further states that a compulsory comprehensive program would call for an estimated 20 percent increase in income taxes. The Administration's bill is the most similar to the AMA's Mediscredit program.

Richard E. Palmer, M.D., AMA president, testified before the Republican platform committee that "there are economic limits to what we can afford as

a nation." Although he feels that health should be a priority issue, total restructure of the system would not be acceptable. The AMA's plan utilizes already proved avenues of delivery that "have provided the American people with the highest quality of medical care."

The Democratic party platform favors compulsory NHI to be financed by employer-employee shared payroll taxes and general tax revenue. Although Governor Carter's acceptance speech contained a reference to a comprehensive health program, and he purportedly favors the Kennedy-Corman bill, Dr. Peter Bourne, a Carter health advisor, has stated that Carter backs no specific Congressional bill. In addition, he has not ruled out the use of private insurance. While discussing federal controls on the physician's private medical practice in an interview with *American Medical News*, Dr. Bourne observed that the more onerous aspects of government intervention would be kept to a minimum. "There is a tendency to impose requirements on the majority of physicians in order to take care of the misdeeds of a small minority. Perhaps in some areas if physicians were more willing to police their own profession. . . . there would be less need for the federal government to get involved."

Either way, health controlled by the federal government will necessitate competition with other



This is a prescription for 20 pounds of wax—to replace some of that candle you've been burning at both ends!

federal agencies for funding in the national budget. Can we really afford to play politics with so precious a commodity?

President Truman faced more difficult odds than does President Ford today. On the other hand, Governor Carter is not behaving as did Governor Dewey. Historical parallels sometimes create illusions. It would be well to remember that in retrospective polls conducted by Gallup and Roper in 1948, many

voters' decisions were made in the last two weeks of the campaign. Neither candidate is elected yet, and both have a chance. It is the duty of every physician, regardless of political persuasion or public opinion polls, to select the candidate who will best serve the country.

David A. Smith, M.D.
Medical Editor



correspondence

Patient has right to know

To the Editor:

Mr. Speaker's article in the August issue of PENNSYLVANIA MEDICINE advising physicians to comply with subpoenas for medical records overlooks one

The correspondent is assistant professor of law at the University of Pittsburgh School of Medicine in the law and psychiatry program, and has contributed articles for publication in PENNSYLVANIA MEDICINE.

very important point. Under Pennsylvania law (28 P.S. & 328) the communications from a patient to a doctor (including those embodied in the medical record) are privileged and may not be disclosed in a judicial proceeding without the patient's consent. Although there are several exceptions to this general rule, physicians would be well advised not only to consult with private legal counsel (as Mr. Speaker recommends) but also to consult with the patient

before releasing the records. The patient ought to know that he has a right to invoke the privilege and prevent release of the record, and ought also to have an opportunity to consult legal counsel to determine whether or not the privilege should be invoked.

The physician's failure to take into account the patient's rights under the privilege statute may render the physician liable to an action for damages by the patient.

Alan Meisel, J.D.
Pittsburgh

August issue praised

To the editor:

Your August issue is a delight; it is the best presentation of the activities and PMS personalities I have ever seen.

I wish all 14,000 members would read it.

George E. Farrar, Jr., M.D.
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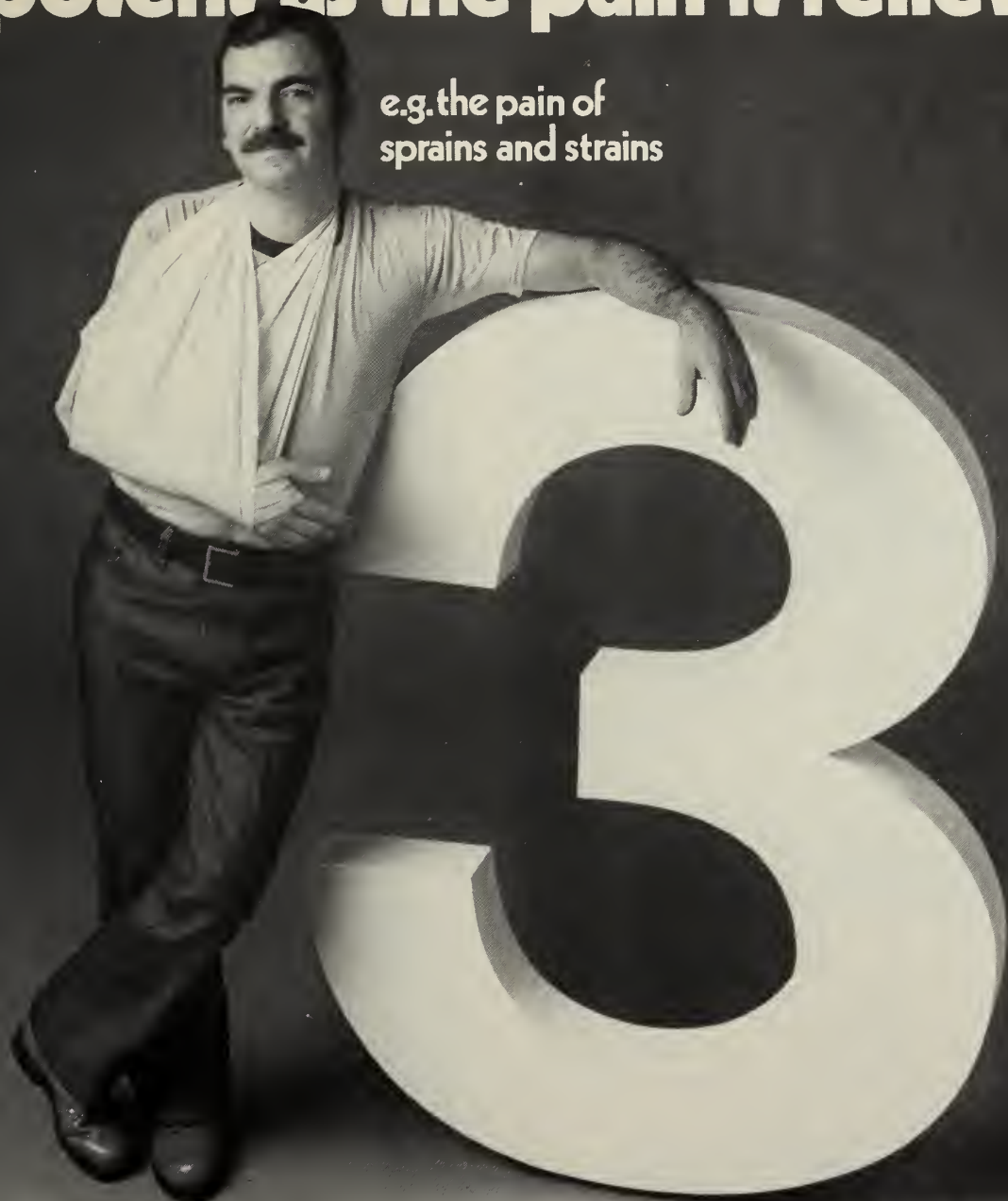
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ABRAHAM J. TWERSKI, M.D.

Pittsburgh

In order that the following account of my encounters with governmental agencies have some coherence, I must tell you something of how I came to be involved with them, and the type of environment out of which I have been operating. I recognize that this may only be a rationalization for my telling you something about myself, for after all, Myself is one of my favorite and most interesting subjects.

Prior to my entrance into medicine, I was a cleric; a rabbi, to be specific. Having grown up under the tutelage of my father, a rabbi who was an acclaimed artist in counseling, I had chosen to follow in his footsteps in what appeared to be a most productive calling. I soon discovered, however, that in this single generation gap, there had been a mass defection from the cleric as personal counselor, and that he was now often in a role of sermonizer and performer of rituals, a role which held little enchantment for me. The cloak of authority for helping people with their problems had been lifted from the shoulders of the clergy, and placed on those of the psychiatrist. The years following World War II saw a great flourishing in psychiatry, which had become the "in thing," and to which I now headed in order to do that which I had hoped to do as a rabbi. Except for a brief romance with surgery, which almost lured me away, I made my way to psychiatry.

My first year of clinical experience as a medical student was in the hospital operated under the direct auspices of the federal government. Having been previ-

ously accustomed as a rabbi to visiting patients primarily in private hospitals, where the stay was generally quite brief, say four or five days for an appendectomy, I could not understand why hospitalization here was of such long duration; e.g., four weeks or more for an appendectomy, it also seemed to me that patients were ordered tests almost for the sake of having tests performed, and that at times the prolonged hospital stay could be detrimental to the patient's welfare, as when they picked up infections from bacteria within the hospital—bacteria that were much more likely to be resistant to the more commonly used antibiotics.

Eventually I got around to inquiring what this was all about, and I was told that the philosophy here was to keep the beds full and the turnover low. As for all the tests, what did it matter? The patient did not have to pay for them anyway, and the increase in taxation due to the additional expense would be so miniscule a portion of the individual citizen's taxes that it would be virtually unnoticeable.

I noted that when an increase in hospital expenses necessitated,

say a \$20 annual increase in hospitalization insurance premiums, there was public awareness of this, generally followed by an outcry of protest, and occasionally by legislative or departmental hearings. However, an increase of a billion or so dollars in a multi-billion dollar federal budget could hardly cause raising of the eyebrows. The point is obvious. Including health care in the fiscal budget removes the reality of medical costs from the taxpayer, and decreases the accountability for health expenditure to those who must ultimately pay the bill.

A second exposure to governmentally administered health care was a sojourn of several years on the staff of a state mental hospital. Laurels to the hospital staff for trying to make a go of it with what the state provides them in the way of a budget. If state hospitals are to serve as an indication of how governmentally controlled health care would operate, then we may be in even sadder shape than we thought, for here austerity reigns supreme. Doctor/patient ratios are lopsided, with one physician for hundreds of patients; and salary ranges controlled by the state are not competitive, offering little attraction for additional staff. Patients are assigned to doctors, and have no choice as to who is going to care for them, and since they have no alternative of purchasing care elsewhere, there is nothing they can do in the event of a personality incompatibility with a particular physician. Here it becomes apparent what happens when a patient loses his option to choose who will treat him.

This article is the second in a series by Dr. Twerski recounting his experiences with government's world of paper. Dr. Twerski is medical director of the Gateway Rehabilitation Center and clinical director of psychiatry in St. Francis General Hospital, Pittsburgh.

Perhaps general medicine, even if governmentally controlled, would not be necessarily patterned after either current federal or state administered hospitals. Yet, it is not beyond consideration that governmentally controlled health care—and to finance something is essentially to control it—could easily have some of the shortcomings of either system, or even of both. The only thing that can prevent such developments is the freedom of a patient to choose, and to choose because he controls the purchasing power that enables him to make such a choice.

I must digress at this point to tell you something about the doctor/patient relationship, and to exhort you that no matter at what cost, *do not give up* your freedom of choice with this relationship.

The overwhelming majority of doctors are very sincere in their work and in the care of their patients. Some people like to use the word "dedicated," and mean thereby some kind of altruism, or a selfless devotion towards others. Shall I tell you something? I don't buy it. I simply do not have enough trust in the power of selfless devotion, of pure idealistic altruism, to believe that it will drag a tired doctor out of bed on a cold winter night after an exhausting day, to come check out my chest pain. Nor do I believe that the few dollars he could make are a strong enough incentive. Few of us are so enamoured with money that we will get up in the middle of the night to make a few bucks more. I am a physician, and I speak only for myself, but I would rather sleep than get up for money at that hour.

There is one force which would drag me out of bed at any time of the night, if only because it will not permit me to sleep; and that is that my ego investment in my patients is such, my sense of self-

esteem is such, that I cannot afford to have *my* patients' health deteriorate, because such a deterioration would be a reflection on me, both privately and publicly.

Not too long ago I became aware that an alcoholic patient of mine had relapsed into drinking after only several months of sobriety. I called him by phone and told him I had called to say goodbye. He asked where I was going, and I told him that I was not going anywhere, but that I had heard he had resumed his drinking, and what I knew of the condition of his liver, he would soon most likely be going away on a long long trip, and I wanted to take this opportunity to bid him farewell, and tell him that I thought he really was a nice person, although quite mixed up. He began crying and asked what could he do. I advised him to call a taxi and get down to the hospital immediately.

The following day he asked me, "Doctor, why did you call me? What difference does it make to you?" I responded, "Bill, you are my patient. If you die, my mortality rate goes up. I pride myself on having a low mortality rate, and I don't want you to wreck it for me. As a result of my ego, you are in the hospital now, and you can make another try at recovery."

That may sound facetious, but there is some degree of truth to this. In addition to dedication toward people and a respect for human life, which is part of the motivation of every good physician, there is an important ego factor involved which ties a doctor to his patient. This is in addition to the personal bond which gradually develops between a doctor and his patient. It is these latter two factors that I will trust in and hope will be operative if I ever develop chest pain on some sub-zero night. I want my doctor to feel a personal responsibility for me, to the point that he will be

unable to rest when he knows that I need him.

Governmentally-administered medicine threatens to subvert this unique relationship of responsibility. When a doctor must answer to the patient, there is good quality control. When the doctor is reimbursed by the patient, there is freedom of choice. When the doctor is chosen by the patient and a relationship is maintained, there develops a sense of responsibility and an emotional investment in the patient. If the doctor, however, answers to a government agency, is paid by the bureaucracy, and is randomly assigned to patients, the most important therapeutic modality is jeopardized.

After a two-year period of service with a state hospital, I took the position as clinical director of the department of psychiatry at St. Francis General Hospital, Pittsburgh.

A word about Pittsburgh. For some reason, there is a piece of legislation somewhere that prohibits this city of some two million population from having a city or county general hospital, such as other major cities in the United States have. Why this is so, I cannot tell you, but such legislation exists; legislation, incidentally, which was drawn up and adopted by some branch of government. It is well to note that several years ago one of the states decided to research its statutes, and remove from the books those laws which were obsolete. In the process of this review of old laws, it was discovered that in the early days of railroad, a statute had been passed that read, "When two trains meet, each is to come to a complete stop, and neither is to resume movement until the other has passed." This is a good example of the kinds of laws that can be adopted by government, and hardly a reassuring thought if the care of our lives is to be turned over to management by legisla-

tive and bureaucratic directives.

As I began to familiarize myself with my department, which consisted of close to 300 of the hospital's 800 beds, I noticed that about 80 of these beds were occupied by elderly people, none of whom were mentally ill in the usual sense of the word, but who were rather helpless and feeble old folks, confused and unable to care for themselves as a result of deterioration due to advanced age. Some of them had been there as patients for several months, others for as long as two years. All they required was supervisory care such as would be available in a nursing home or an institution for the aged, with three meals a day, looking after their personal needs and cleanliness, supervision that they do not walk away and get lost, etc. Yet here they were in the department of a general hospital for months and years, at a cost about four times that of a custodial institution! How had this come about?

I then discovered another piece of governmentally engineered snafu (situation normal; all fouled up). About ten years earlier, some citizens of the community had arisen in protest, because mentally ill people, most of them completely harmless, were being detained in jail. Why? Because our governmentally-operated hospitals could not accept new admissions except between 9 a.m. to 5 p.m. Monday through Friday. Why? Because they did not have adequate staff evenings and weekends to process new admissions. Why? Go ask state government. As a result of these restrictive admission hours, persons who needed admission to a mental hospital "after hours" were being housed in jail overnight or over the weekend, until the shop opened its doors.

What would have been the sensible solution to this problem? Reasonable people would have

realized that a hospital is not run like a department store, and must be staffed, equipped, and funded to admit and care for patients at any time the need arises. But government cannot operate rapidly enough to implement such a change even if it wishes to (which it apparently did not). Instead, city, county, and state bureaus got together to provide a typically governmental solution: a stop-gap measure.

Have you ever thought about how many times government employs various types of stop-gap measures? And have you followed up on what happens to these stop-gap measures in the long run? You will find that these temporary patches are permitted to remain, and are eventually perpetuated as permanent fixtures. With patch after patch of makeshift stop-gaps being applied, any governmental system eventually begins to look like a structure held together with scotch tape, and operates with commensurate efficiency. Has anyone noticed the efficiency of our postal system, where expense and services appear to be traveling in diametrically opposite vertical directions?

Anyway, the three levels of government got together and arranged for a stop-gap measure. They requested that St. Francis General Hospital set aside a maximum of ten beds for the *overnight or weekend* care of mentally ill persons who would have otherwise had to be held in jail. This agreement was drawn up in writing, with assurances that within no more than 48 hours, these patients would be admitted to the state hospital, so that the designated beds could be utilized for subsequent "hold-over" admissions. Once the crisis had been averted by this finger-in-the-dike measure, nothing, but nothing was done to correct the basic inadequacies of the gov-

ernmental hospital system, which has remained inadequate to this very moment.

In the meantime, the government hospital pulls a fast one. Oh, yes. Something else about governmental systems. Although there is a central office at some level that is responsible for all outposts within the system, each unit retains its autonomy insofar as doing what it wants to within its allotted budget, and the system is so large and complex that the man at the capital level cannot possibly have effective control of all units. Consequently, each unit head has his little fiefdom. However, being part of the governmental system permits endless passing-the-buck to and fro, with no one capable of satisfying anyone's complaints. The local hospital unit blames the guy in the capital, and he in turn shifts it back to the local level. If the system is big enough, a "regional" intermediate is also provided, so that there are three places where your complaint may be displaced, pigeon-holed, or shifted. Remember this when you consider turning your ulcer over to governmental management.

The trick pulled by the state hospital was to arbitrarily set a limit to their census of patients over sixty-five years. Thus, any patient taken in as a "hold-over" for up to 48 hours had to go on a "waiting list," which just grew and grew and grew. By the time I assumed my position at St. Francis, there were 80 of these elderly people, being cared for very adequately, but at a general hospital cost four times that of an appropriate supervisory-care facility; a cost borne by the taxpayer. Of even greater concern than the cost was the fact that acute general hospital beds were being grossly misutilized, and hence unavailable for the care of patients who really needed them. □

(Continued in November)

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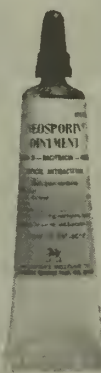
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Practice management tool of risk control

LEIF C. BECK, LL.B.

VASILIOS J. KALOGREDIS, J.D.

Bala Cynwyd

Can your office routine bring out a patient's litigious nature? These authors say yes, and tell you how to avoid this pitfall!

The medical malpractice climate has a variety of causes, one of which is a supposed deterioration of the physician-patient relationship of trust and confidence. In our view, that relationship is adversely affected by the practice management shortcomings of some offices. In effect, many doctors retain a unique concern for and desire to serve their patients, but they permit their office systems (or lack of systems) to create a contrary image. The image will, in cases of marginal or unsuccessful medical results, too often influence patients to bring malpractice actions.

We believe a practice's exposure to malpractice claims can be reduced by attention to effective practice management. Since the cost of such claims are so high, including increased insurance premiums, demands on a physician-defendant's time, and (most of all) drain on his emotions, the attention devoted to developing good management systems cannot be overemphasized. This article explores some of the business aspects from which malpractice claims can too easily arise—and some basic ways to handle them.

Telephone

How many times have we called medical offices and been greeted by busy signals? The answer is obvious, and yet we often wonder what would happen if the unsuccessful caller were a regular patient in an emergency. The office's mechanical unresponsiveness is simply one of the most grating experiences a patient can have—certainly one which makes him feel the doctor is too busy to care.

We believe that a practice simply must have enough incoming telephone lines to adequately serve its patients. This is an obligation which should not be avoided by some casual feeling that the patients can keep trying until they "get through." Even the excuse that the office receptionist cannot handle any more lines should be disregarded, for there are a variety of possible solutions. They include adding a second receptionist, creating a separate

insurance and/or business office line(s), adding additional outgoing lines to clear the "in" lines, etc. Even if the solutions carry additional costs, they should be acceptable both to serve the existing patients properly and to avoid real embarrassments.

We experienced a "real life" example of our telephone concern in a fairly recent practice survey. In that busy primary practice office, the receptionist often answered calls by placing a caller on immediate "hold." One patient was placed on "hold" before being able to report a choking emergency; she was left "holding" until she finally hung up and called for an ambulance. The patient was brought to the local hospital and thereafter transferred to a regional special care center. Whether or not the client doctor could have prevented the near-tragedy if the call had gotten through is conjectural even to him. But one can certainly imagine the patient's attitude.

We urge several absolute rules as to incoming phone calls. First, no call should ever be placed on "hold" before the caller has had an opportunity to announce himself and any special reason for his call. Second, no line may be kept on "hold" for more than 30 seconds without someone's speaking to the caller, if only to assure him that he has not been forgotten. In offices where one person has primary responsibility to answer the phone, we believe there must be a clear identification of one or several other assistants who have secondary responsibility to pick up and recontact callers on blinking "hold" buttons.

Some doctors feel that they are being most responsive to their patients by taking all phone calls, even if interrupted during patient examinations. We, however, believe that this policy is damaging to their general patient relations. The interruptions interfere with the patient who expects attention to his problems while being examined, and they cause an increasing backlog in the waiting room.

We submit that the doctor's first obligation during office hours is (except for emergencies) to the scheduled patient. To give that patient less than prompt and complete attention invites the state of mind which may permit a malpractice action to develop. The preferable answer would be to provide for "call-backs" to patients when there is a lull in the office hours; and if no such lulls

The authors are the principle consultants of Management Consulting for Professionals, Bala Cynwyd.

generally occur, the pre-arranged schedule should provide "open time" for call-backs.

Scheduling patients

We realize that some doctors are so busy that there seems virtually no possible way to stay on schedule. And so waiting rooms become crowded with patients one and two hours behind their scheduled times. In some cases we suspect the state of patient volume and delay becomes a doctor's subconscious ego gratification, but it also creates horrible patient relations. As patients in waiting rooms we ourselves have seethed, alternating between awe at the probable pressures on the doctor and fury at his disregard for our own time demands. If dissatisfied at the result when finally seen by the doctor, we have been tempted to join the malpractice bar.

Perhaps one very recent survey example will be helpful. In a specialty group, one of the doctors was regarded by many as the best of his specialty in the area. He tended to run as much as two hours behind his office hours schedule, however, much because he tolerated "work-in" patients whether or not they really needed immediate attention. Likewise, in the hospital his schedule ran helter-skelter due to his failure to establish limits and priorities. Despite his medical reputation among many, he had been subject to five or six malpractice suits while his partners (who more consciously managed their schedules) had none.

Just as with telephone calls, we believe a physician has an obligation to his scheduled patient. It includes refusing to honor other patient demands (except emergencies) which detract him from his schedule. It also includes scheduling only as many patients as can reasonably be seen *on time*, rather than working in more and more people with the shrug that everyone will simply have to wait.

There are some steps which may help alleviate constant schedule delays. They essentially involve the principle that "The appointment book should fit a practice's facts; and not vice versa." Under this rule, each doctor can consider such possible scheduling ideas as wave scheduling, open hours for work-ins, grouping of similar procedures, and the like.

In some offices the patient volume is simply so heavy that these concepts will hardly make a difference. There are then only a few remaining alternatives: expand the office hours, add another physician, employ a physician's assistant or Medex, close the practice to additional patients, or simply continue as is. This last choice commits the practice to the same helter-skelter life, including the risks of patient complaints and/or errors in judgment due to lack of time—prime sources for malpractice.

Billing and collecting

It is commonly recognized that disputes over patients' bills may lead to patient malpractice actions in cases of marginal or unsuccessful medical results. We believe that every office should thus have effective systems which collect the fees but avoid rancor.

The best malpractice protection in this area is immediate collection of the fee before the patient even leaves the office. Collection over-the-counter presents the bill when

the patient should most appreciate the service. Studies have shown that the appreciation level diminishes as the time gap widens. Furthermore, the actual collection assures that no followup efforts will be needed, thus avoiding a later source of embarrassment or annoyance between doctor and patient.

If the practice does not participate in Blue Shield or accept medicare assignments, so that it looks directly to the patient for payment, it should have deliberate procedures to "train" the patients. Many patients in Pennsylvania have come to assume that coverage means full insurance, in which case receipt of a doctor's bill can be a shock. An even worse relationship can arise when the Blue Shield or medicare payment to the patient is less than the doctor's bill. The patient's direct obligation to the doctor and the likelihood that insurance will reimburse less than the doctor's full fee should be made clear before the services are performed, if at all possible, usually by a printed notice or booklet handed to the patient.

As a patient's account becomes delinquent, effective collection measures must be activated; but these methods must not create the ill will which might permit law suits to develop. We believe, therefore, that every office's collection system should require telephone contact to the patient as early as possible. This personal discussion may ferret out the patient's reason for not yet paying his bill, which reason might be dissatisfaction with the service or the result or real inability to pay. The sooner an office becomes aware of such reasons, the sooner it can cut short its series of dunning notices and/or collection agency pressures.

Finally, referral of delinquent accounts for collection by others presents real malpractice concern. A doctor should generally be more concerned over an agency's collection processes than its success rate, for some agencies collect through near "strong arm" approaches. Such approaches might yield a practice a delinquent fee and also a law suit. Therefore, a collection agency should be hired only after careful review of its procedures to be followed for all the practice's accounts, and only after checking into its work with other medical practices.

As an alternative to collection agencies taking substantial percentages of any recoveries, some practices are instead using collection letter services. The fees are much lower for such services, although only automated letters without personal contact are employed. We urge, however, that no physician sign up with a collection letter system until and unless he has approved each letter to be used for his accounts. Since some collection letter services use very harsh letters, caution can prevent serious legal problems.

Summary

The above are only a few areas of attention deserved for two main reasons: effectiveness of practice and avoidance of some malpractice risks. The ideas, however, require one key element: competent and well-supervised employees. If all medical assistants are groomed to the importance of following well thought-out office systems, the physician will have created a considerable defense against malpractice claims. □

Nerve injuries

WILLIAM P. GRAHAM, III, M.D.
STEPHEN H. MILLER, M.D.
Hershey

Injuries to nerves within the upper extremity can have disastrous consequences for the patient. Despite satisfactory treatment of the injury, sufficient dysesthesia may result to preclude use of the hand.

Nerve injuries may take three forms: neuropraxia or contusion, axonotmesis or axonal interruption, and neurotmesis or complete physical interruption of nerve and its sheath. The prognosis following neuropraxia is excellent while the outcome from an axonotmesis, despite the physical integrity of the neural sheath, is uncertain. Obviously total physical separation of the nerve mitigates against complete recovery.

A proper examination is essential to discern the extent of a nerve injury and often requires thorough cooperation from the patient. Generally the distal sensory innervation is from the same nerve innervating the muscles that move the digit. Overlapping areas of sensory innervation and cross motor innervation must be appreciated. Substituted motions as well as possible anomalies of innervation must be recognized. Occasionally in evaluating an old injury an anesthetic block may be needed to

eliminate cross innervation or to pinpoint a specific locus of pain along a nerve.

Today a preference exists for primary repair of most divided peripheral nerves. Such repair may be performed immediately or within a day or two of the injury. Early repairs require: good vascularity, minimal wound contamination, surgical experience, and good operating facilities to yield the best result. Most surgeons use either the operating microscope or at the least four power magnification with loupes. The advantages of early repair are the decreased disability time for the patient, single operative procedure, less retraction of the two nerve's stumps, and the absence of severe scarring about the nerves. The proponents of delayed repair believe that a more accurate assess-

ment of the extent of injury can be made at a later date, the risk of infection is lessened, and the patient can be more ideally prepared for the operation and his role in his own convalescence.

The predictability of recovery from a properly treated nerve injury depends upon: the nature and degree of the injury; the magnitude of the associated injuries; the age of the patient; his unique healing properties; and his cooperation and assumption of responsibility in working for his own recovery. Massive injuries with associated ischemia, excessive scarring, loss of nerve substance, increased age, and the patient who has suffered an incisive wound with little associated soft tissue injury may expect to achieve a reasonable level of function following neurorrhaphy. □

This paper was prepared by the department of surgery, division of plastic surgery, The Milton S. Hershey Medical Center, The Pennsylvania State University, Hershey. The Pennsylvania Division of the American Trauma Society and the State Society's Commission on Emergency Medical Services assist in the dissemination of information on trauma.

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A plea for better interprofessional communications

GLEN P. McCORMICK, PH.D.

Butler



Dr. McCormick, chief of audiology/speech pathology for the Veterans Administration Hospital, Butler, received a Ph.D. degree in 1965 from Purdue University. He is certified in speech pathology and audiology by the American Speech and Hearing Association.

Today's health literature—both lay and professional—is filled with articles critical of health care in America. Many professional journals previously devoted to discussions of illnesses peculiar to patients have begun to carry more and more articles dealing with the illnesses of the health profession itself.

At the risk of overtaxing the abundantly discussed topic, the writer wishes to expound upon his experiences, not because they are unique, but because they are similar to the experiences and complaints of other rehabilitators. In this age of criticism a frank discussion of grievances is

needed if a further deterioration of our health care system is to be prevented.

One does not need to travel far through the maze of interprofessional relationships to understand that physician/non-physician accord is problematic. To be specific, virtually all the professions ancillary to medicine have developed to a point which demands more teamwork among professionals; the demand is as natural as it is difficult for physicians to accept.

A cursory review of current literature might lead some persons to conclude that the dissatisfactions expressed relate only to the doctor/nurse rapport. There is only partial truth to such an assumption.

Smoyak,¹ in a blunt article dealing with the long-standing doctor/nurse intrigue, attributes much of the current difficulty to "covert game playing" which compromises the quality of patient care. Numerous articles cite the increasingly poor doctor/nurse relationship, and Shetland² speaks well for nurses irate in learning of formal meetings convened to redefine the roles of nurses—meetings convened without nurse collaboration.

Aside from Shetland,² the need for role-adaptation has been approached by numerous writers: Goerke,³ Doster,⁴ Steinberg, Shatz and Fishman,⁵ etc. However, the persistence of the controversy suggests that the acceptance of role change, especially for nurses, remains incomplete.

That change is undertaken is reflected by the thoughts of Fagin⁶ who

concludes that, while nurses have finally established the right *not to do*, now is the time for nurses to grasp fully the right *to do*. Ashley,⁷ by reviewing the nursing movement in America from a historical viewpoint, cites professional indignities and injustices from physicians and hospital administrators, concluding that second-class citizenship (for nurses) has resulted in second-class professionalism as well. An example of how the controversy has peaked is available from Cleary⁸ who, in discussing a nurses' strike at a Philadelphia hospital, reveals that the nurses struck for more recognition of their skills and for a more acceptable role in patient care—as opposed simply to a work-stoppage for more money.

That the role of nurses is changing is also described by Bergeson and Melvin,⁹ a doctor-nurse team utilizing nurse practitioners on hospital staffs. Thomstad, Cunningham, and Kaplan,¹⁰ a physician-nurse-social worker triad, report on a similar team approach, their overall plan having been based on a new doctor-nurse direct-communications relationship—often painful—from which they derive the set of "old" versus "new" doctor/nurse rules in Table I.

Not all the discussion pertaining to the doctor/nurse controversy comes from nurses. Weiler,¹¹ a physician, provides a thoughtful article dealing with the concept of "dialectic" to explain how the training of physicians, nurses, and physician's assistants has actually created "role" problems. Weiler comments on the fact that nurses in particular have begun to rebel at the threat of losing their "pro-

fessional turf," are dissatisfied at traditionally receiving "hand-me-down" tasks, and are at the forefront of an array of health specialists seeking self-actualizing professional appointments.

In addition to the nurse-led movements for better professional working relationships, one finds reports by Nelson, Jacobs, and Johnson,¹² and by Coye and Hansen¹³ about the general acceptability of physician assistants. To counter earlier charges, Nelson, et al,¹⁴ study the financial impact of such personnel, concluding that their services have created "neither a financial windfall nor a liability."¹⁴

That numerous health specialists are concerned for their role is further evidenced by Randar,¹⁵ a social worker calling for better utilization of the skills of social workers, and by Zallen,¹⁶ a registered dietitian who attributes current nutritional problems to situations which came *after* hospital administrators forced dietitians away from clinical food services and into the preparation and distribution of hospital foods. There is a fundamental lesson to be learned from such a cornucopia of dissatisfaction.

A number of persons attribute to the nationwide movements among health professions a dissatisfaction based upon undeserved egotism, jealousy, and greed. While there may be a certain amount of truth in such beliefs, the writer attributes the movement to a natural process based upon *education* and a true and literal sense of *professional responsibility*.

Education

In the not too distant past health care primarily involved physicians, nurses, and other acute care oriented persons from the basic sciences. For years these persons fought to understand human physiology, worked to comprehend disease processes, and hoped to forestall death. That these early health workers were essentially successful is a tribute to mankind's diligence and wisdom.

While these basic science practitioners were developing their skills, another system of specialists was evolving—the behavioral scientists. This latter group, somewhat newer to the scene, for a variety of reasons tended to develop their training pro-

TABLE I Doctor-Nurse Game	
Old Rules	New Rules
1. Medical care is more important than nursing care.	Good health care requires both good nursing care and good medical care.
2. The nurse can help the doctor as long as nobody knows about it, including the doctor.	The doctor and nurse are both there to help the patient and have to communicate directly and openly to do so.
3. The doctor knows more than the nurse.	Good doctors know more medicine than good nurses; good nurses know more nursing than good doctors.
4. If the doctor tells patients what to do, and they don't do it, it's the patients' fault. The doctor did his best.	If a health care plan is to be carried out, it must be worked out with the patient's needs, beliefs, and capabilities in mind.
5. Doctors are so busy that nurses may have to take over some of the tasks.	Many doctors don't like or know much about health care. Nurses are prepared in this, like it, and are usually better at it than doctors.
6. Good doctors rarely make mistakes and see to it that others don't either.	Everyone makes mistakes, but open communication between doctors and nurses minimizes them.

grams apart from physicians and nurses, which led not only to a physical separation of personnel, but to philosophical separations as well. Health care to this day is compromised by this rift which has not been adequately repaired.

Perhaps on the basis of exposure, i.e. time, the wares of basic scientists are better known, more easily quantified, and carry greater authority. However, within the past twenty-five years the behavioral science practitioners have developed their skills to acceptable levels and fully expect to be recognized for their potential contributions to health care, as are their counterparts in the basic science areas. One essential problem remains to plague both groups: the acceptance of one another as co-equal workers for humans afflicted by illnesses.

To overcome the diversity of opinion and inter-professional non-acceptance, the writer contends that this country's medical educators must adopt forms of training which will create within medical students a sense of respect for the many non-medical health workers who are now legitimately on the scene. The writer, not inexperienced in the realm of medical education, feels that this issue could be resolved *if* the medical educators teaching today were to spend but one half as much time teaching their charges to respect

others, as others spend teaching respect for the role and responsibilities of physicians.

Professional responsibility

Mase,¹⁷ in dealing with the health team concept, stipulated that modern Americans were not only well informed on health topics but also had been educated to consider health care a basic right, as opposed to a privilege. To partake of this "right," teamwork is necessary. Yet, in keeping with the need for teamwork, Dewhirst¹⁸ cited a hospital tradition by stating that, "...The tradition was and still is that physicians, not hospitals or their employees practice medicine..." The writer contends that Dewhirst's statement is essentially correct for a too large number of tradition bound hospitals. Because of this, the newer, behaviorally oriented health workers find it distressingly difficult to have access to patients, to have a voice in the policies which guide patient care, and to feel a comradery with the physicians or institution from which the group morale is derived.

While some persons might encourage the newer disciplines to be more patient in achieving "self actualization"—if that is indeed their goal—it must also be considered that advances in acute care have given

rise to populations of patients struggling through the miseries of chronic disabilities. Thus, by asking behaviorally oriented rehabilitators to be less aggressive in establishing their rightful role in health stratagems, such advice is the same as encouraging them to ignore the suffering and unhappiness they were trained to offset. Such a posture is untenable, guilt-engendering, and contrary to the nature of health workers, be they acute care or rehabilitatively inclined. It is doubtful that today's health specialists could rationalize any call based so heavily on tradition rather than logic.

Conclusion

America's health problems are complicated by the presence of large numbers of patients—and their families—requiring attention for acute as well as chronic conditions. Education within the myriad health disciplines has generated workers representing the basic and behavioral sciences, but has failed to teach an adequate amount of teamwork between the two.

From a traditional vantage point some physicians and hospital administrators work to suppress the

self-actualizing moves made by workers ancillary to medicine. For those workers described by Anderson¹⁹ as members of the "helping professions," it is unfair to presume that their motivation for change relates strictly to the desire for professional gain, since the same drives for humanness affect them, as did the drive in acute care affect earlier generations of basic science personnel.

Is it possible that the entire concept of medicine has changed? The writer suspects that it has, giving rise to a vast army of highly skilled health workers who consider themselves involved in the "practice of medicine," without designs on those known as "medical practitioners."

The quality of life sought by all Americans can only be achieved by skilled teamwork effected through open communications between disciplines. For those physicians and hospital administrators inclined to deny patients the services of the relative newcomers to medical care, the writer can only say: "Try us. You'll like us!" □

REFERENCES

1. Smoyak, Shirley A. (Reprinted) Nurses and physicians: toward professional equality. *Am. Acad. Ped.* 25: 6, 1974.

2. Shetland, Margaret L. An approach to role expansion: the elaborate network. *Am. J. Pub. Health*, 61: 10, 1971.
3. Goerke, Lenor S. Utilization, recruitment, and training of health manpower. *Am. J. Pub. Health*, 55: 10, 1965.
4. Doster, Daphne D. Utilization of available "nurse power" in public health. *Am. J. Pub. Health*, 60: 1, 1970.
5. Steinberg, S. S.; Shatz, Eunice O.; and Fishman, J. R. New careers: a major solution to the environmental health problem. *Am. J. Pub. Health*, 59: 7, 1969.
6. Fagin, Claire M. Nurses rights. *Am. J. Nursing*, 75: 1, 1975.
7. Ashley, JoAnn. Nursing and early feminism. *Am. J. Nursing*, 75: 9, 1975.
8. Cleary, D. M. A nonstrike for patient care. *Modern Healthcare*, 3: 6, 1975.
9. Bergeson, P.; and Melvin, Nancy. Granting hospital privileges to nurse practitioners. *Hospitals, J.A.H.A.* 49: 16, 1975.
10. Thomstad, Beatrice; Cunningham, N.; and Kaplan, Barbara H. Changing the rules of the doctor-nurse game. *Nursing Outlook*, 23: 7, 1975.
11. Weiler, P. G. Health manpower dialectic: physician, nurse, physician assistant. *Am. J. Pub. Health*, 65: 8, 1975.
12. Nelson, E. C.; Jacobs, A. R.; and Johnson, K. G. Patients' acceptance of physician's assistants. *JAMA*, 228, 1974.
13. Coye, R. D.; and Hansen, M. F. The "doctor's assistant." *JAMA*, 209, 1969.
14. Nelson, E. C.; Jacobs, A. R.; Cordner, Karyn; and Johnson, K. G. Financial impact of physician assistants on medical practice. *N. Eng. J. Med.*, 293, 11, 1975.
15. Randar, Mary Ann T. Expanding the role of the social worker in the health field. *Am. J. Pub. Health*, 62: 8, 1975.
16. Zallen, Eugenia M. Let's reforge the link. *Nutrition Today*, 10: 2, 1975.
17. Mase, D. J. Professionalism and the health care team. *J. Allied Health*, Spring, 1975.
18. Dewhirst, H. D. Curb credentialism! *Hospitals, J.A.H.A.*, 49: 13, 1975.
19. Anderson, T. P. An alternative frame of reference for rehabilitation: the helping process versus the medical model. *Arch. Phys. Med. Rehab.*, 56, 1975.



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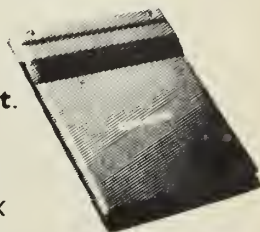
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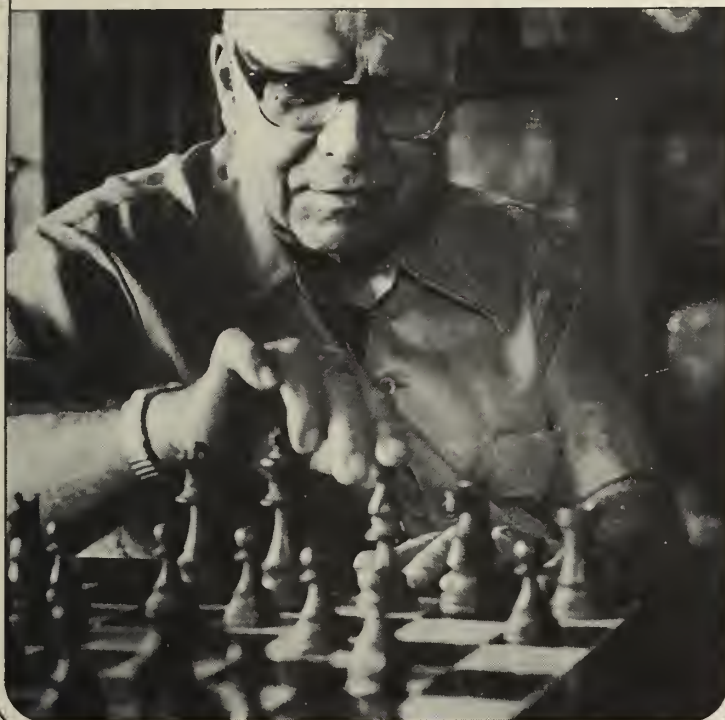
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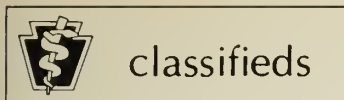
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Physicians—Openings for family practice, general practice, and emergency room physicians in a small college town near major medical centers. Growing area, clean air, ideal family setting. New 120 bed hospital. Solo or group. Call collect or write: Administrator, Greene County Memorial Hospital, Waynesburg, PA 15370; (412) 627-3101.

Family Practice Physician—Board eligible or certified, to join solo practitioner in Carlisle, Pa. Gary L. Blacksmith, Jr., M.D., 323 York Rd., Carlisle, PA 17013; (717) 243-4112.

Chief, Medical Service—Vacancy in 500 bed hospital complex. Board certification or eligibility in internal medicine. Physician will be involved with continued implementation of progressive changes for coping with expanding inpatient and outpatient treatment programs. Salary ranges up to \$37,800 plus \$11,000 special pay dependent upon qualifications; excellent fringe benefits. Suburban living and yet close to metropolitan educational, social, and cultural center. Licensure any state. Non-discriminatory employment. Contact Chief of Staff, VA Hospital, Butler, PA 16001. Telephone (412) 287-4781, ext. 210.

Emergency Room Director—A 201 bed progressive JCAH accredited hospital is seeking a qualified full time emergency room director. Salary commensurate with training and experience. Excellent fringe benefits. Hospital is presently undertaking a \$16.1 million renovation and modernization program, which will include a new emergency department and ambulatory care facility in the seven story addition. Hospital's primary service area consists of 70,000 population. Located 99 miles from Pittsburgh area in Central Pennsylvania. Please send re-

sume only to: Mr. G. F. De Laura, Assistant Administrator, Mercy Hospital, 2601 Eighth Ave., Altoona, PA 16603.

Radiologist—Board eligible or certified, to join group covering two hospitals with a proposed expansion to third. Training in angiography essential. Experience in ultrasound or CT desirable. Immediate opening. Reply to: Melih Gurgun, M.D., Director of Radiology, Forbes Hospital System, Columbia Health Center, 312 Penn Ave., Pittsburgh, PA 15221.

Emergency Department Physician—M.D. or D.O., Pennsylvania licensed. Modern JCAH accredited 250 bed hospital in central Pennsylvania. Two physicians needed immediately to round out current staff. Excellent financial and fringe benefits. Write Department 731, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

Director of Student Health Services—Licensed physician; full time position directing health center for 6,000 students. Supervises two full time associate physicians plus supporting staff. Submit resume by November 1, 1976, to: Lehigh University, Personnel Office, Bldg. #36, Bethlehem, PA 18015. An Equal Opportunity Employer.

OB/GYN Physician—Board Certified or Board Eligible, wanted to work in an outpatient abortion and family planning clinic located in Harrisburg, Pa. Pennsylvania medical license is required. Immediate position. Send curriculum vitae to: Hillcrest Clinic Executive Business Office, 3214 Pennsylvania Ave., S.E., Washington, D.C. 20020.

Emergency Services Director—Recently expanded general hospital with new ER seeks a licensed, qualified physician to direct emergency room. Prefer physician with emergency and administrative experience to fill this key position. 42 hour week, generous fringe benefits and competitive salary. Hospital located in the Delaware Valley area. Send curriculum vitae and references to: Donald T. Hauk, St. Francis Hospital, 7th and Clayton Sts., Wilmington, DR 19805. Equal Opportunity Employer.

Active Orthopedic Surgeons located in northeast Philadelphia and adjacent suburbs seeking orthopedic

resident finishing accredited residency. Position open. First year salary and partnership after one year. No investment needed. Send curriculum vitae. Write Department 730, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

OB/GYN Physician—Can be hospital based or will be assisted by the hospital in establishing practice in a very desirable service area of 50,000 population. Good hunting and fishing. Access to metropolitan areas of Pittsburgh, Philadelphia, and New York by interstate highways. Staff privileges at progressive community hospital located within commuting distance of Penn State, Bucknell, and two other colleges. Contact A. W. Speth, Administrator of Lock Haven Hospital, Lock Haven, PA 17745; or call collect (717) 748-7721.

Family Physicians—Openings in areas of medical care in a large psychiatric hospital which is fully integrated with community agencies, hospitals, and base service units. Conveniently located near city of Pittsburgh. Accredited by J.C.A.H. and meets standards for Medicare, Medicaid, and Medical Assistance. Salaries range to \$30,690 with excellent fringe benefits including opportunities for continuing medical education. Pennsylvania license required. Contact Dr. F. C. Wagenseller, Director of Medical Services, Mayview State Hospital, Bridgeville, PA 15017; (412) 343-2700.

Internist—Board Certified or Board Qualified to join hospital based first year for service area of 50,000 population. Good hunting and fishing and outdoor activities. Has local college, also near Penn State and Bucknell. Two other colleges within commuting distance. Good access to metropolitan areas such as Philadelphia, New York, and Pittsburgh by air and express ways. Excellent primary and secondary school systems. Privileges in progressive community hospital undergoing variety of expansion programs. Noted for leadership in rural medicine. Contact A. W. Speth, Administrator, Lock Haven Hospital, Lock Haven, PA 17745; or call collect (717) 748-7721.

FP/GP For Innovative Family Health Center in North Central Pennsylvania. To join 4 family practice general practice physicians, 2 dentists, and a psychiatrist in providing comprehensive primary health care. Excellent salary and fringe. Teaching opportunity in FP residency. Rural area with convenient cultural and outdoor activities. J.W. Montague, M.D., Medical Director, North Penn Family Health Center, Blossburg, PA 16912.

Orthopedic Surgeon Wanted—Associate for well established Orthopedic Clinic in Eastern Pennsylvania. First year, salary plus percentage. Partnership after one year. Board eligibility required. No investment needed. Write Department 709, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

Family Practice Physician Needed—In family oriented community in eastern Pennsylvania; town 6,000; rural drawing area 15,000 population; good schools and recre-

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Wanted Immediately—Orthopedic surgeon to associate with established orthopedic surgeons incorporated in southwestern Pennsylvania; must have Pennsylvania license; salary negotiable with all benefits. Write Department 733, PENNSYLVANIA MEDICINE, 20 Erford Road, Lemoyne, PA 17043.

GP, FP, Internist, and Pediatrician—Needed for multi specialty, hospital based group practice. New medical office building, adjacent to new 231 bed general hospital, will finish to suit. Highly competitive and flexible financial arrangements. Large, growing draw area, near Pittsburgh. Contact John McCarroll, Director of Ambulatory Care Services, Braddock General Hospital, Holland Ave., Braddock, PA 15104; (412) 351-3800.

Emergency Room Physician—Full time emergency room physician for community hospital. Liberal income guaranteed. Telephone Personnel Director, Delaware County Memorial Hospital, Drexel Hill, PA 19026; (215) 259-3800, ext. 310. Equal opportunity Employer.

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Endocrinologist/Internist—University, NIH trained, board eligible, desires group/associate practice opportunity in metropolitan Philadelphia area. Available July 1977. Write Department 728, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

Pulmonary-Internist—Pennsylvania licensed, university trained, AOA, U.S. citizen. P.F.T.s, fiberoptic bronchoscopy. Desires medium sized community with good schools. Practice type flexible. Available July 1977. Write Department 732, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

Pathology Resident—Board eligible in anatomical pathology in November 1976 desires associate position in anatomical pathology starting July 1977. Contact Michael F. Doyle, M.D., Pennsylvania Hospital, 8th and Spruce Sts., Philadelphia, PA 19107.

General Surgeon—31, American, university trained, passed Part I of Boards, presently completing Army obligation, experienced in gastroscopy and vascular surgery. Prefer location in Philadelphia area but will consider all locations. Available July 1977. Write Department 729, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

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Family Practice or OB/GYN Office Space—For physicians who left practice each netting \$100,000 yearly. Modern medical building overlooking Lake Erie with 15 other physicians near Hamot Hospital Medical Center. Charles E. Kibler, M.D., 140 W. 2nd St., Erie, PA 16507; (814) 454-3464.

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Young Diagnostic Radiologist—Board certified, 1973, 4 years experience in hospital as chief of diagnostic radiology, wishes to purchase or lease private office. All locations considered. Training in xerography, ultrasound, and nuclear medicine. Write Department 734, PENNSYLVANIA MEDICINE, 20 Erford Rd., Lemoyne, PA 17043.

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• Indicates membership in the Pennsylvania Society at time of death.

• **Joseph Aspel**, Merion Park; Jefferson Medical College, 1915; age 82; died July 5, 1976. At his retirement in 1972 he had practiced medicine 56 years and in 1965 was a recipient of the Society's fifty year award. His wife, a son, Bennett Aspel, M.D., a daughter, and brother, and a sister survive him.

• **William F. Betsch**, Philadelphia; Harvard Medical School, 1943; age 59; died July 27, 1976. He was medical director of the Philadelphia Electric Company. In 1964 Dr. Betsch was instrumental in the development of a pioneer program in radiation medicine for Philadelphia Electric's Peach Bottom nuclear power plant and later helped to establish a radiation support facility for the University of Pennsylvania. He was on the medical staffs of the Pennsylvania and Thomas Jefferson University Hospitals, and was an associate in clinical medicine at Jefferson Medical College. He is survived by his wife, a son, and a daughter.

• **Donald D. Dunkle**, Lititz; Jefferson Medical College, 1953; age 52; died July 12, 1976. He was in private practice from 1954 until 1966 when he joined a team of emergency physicians at Lancaster General Hospital. His wife, a daughter, and two sons survive him.

• **Paul H. Fried**, Philadelphia; Jefferson Medical College, 1939; age 61; died July 24, 1976. A former instructor at Jefferson Medical College, he was a member of the executive medical board of Jefferson. He had served as president of the University of Pittsburgh Alumni Association. His wife, five daughters, and two sisters survive him.

• **James R. Gemmill**, Pittsburgh; Medico-Chirurgical College of Philadelphia, 1913; age 88; died July 12, 1976. He was a member of the Pittsburgh and Pennsylvania Radiological Societies. His wife, two daughters, two brothers, who are William P. Gemmill, M.D., and Walter D. Gemmill, M.D., survive him.

• **Samuel P. Harbison**, Pittsburgh; Cornell University Medical College, 1936; age 67; died July 19, 1976. He was director of admissions in the University of Pittsburgh School of Medicine. Having joined the faculty in 1945, he was later named professor of surgery and became the first full time chairman of the department. He was associate dean in the school of medicine from 1963 until 1975 when he became director of admissions. He was a member of the Allegheny County Medical Society Board of Directors 1964 and 1970-73. He served on the medical staffs of Presbyterian-University, Magee-Womens, and Eye and Ear Hospitals, and was a consulting surgeon for the Veterans Administration Hospital. He is survived by his wife, a son, and a daughter.

• **Luther H. Kline**, Allentown; Jefferson Medical College, 1926; age 76; died July 4, 1976. He had practiced

medicine over fifty years before his retirement in 1975. He had been a member of the medical staffs of Allentown and Sacred Heart Hospitals. His wife, a daughter, two brothers, and two sisters survive him.

• **Alexander D. Martin**, Colver; University of Toronto Faculty of Medicine, 1921; age 77; died July 2, 1976. He had practiced 41 years in Colver until retiring in 1965. The community of Colver named a park for him in 1974 in appreciation of his service to them over the years. He is survived by his wife, a son, and a daughter.

• **Patrick F. McHugh**, Wilkes-Barre; Jefferson Medical College, 1911; age 88; died July 17, 1976. A daughter survives him.

• **Sidney G. Odle**, Pittsburgh; University of Pittsburgh School of Medicine, 1931; age 71; died July 27, 1976. He was former clinical instructor in medicine, senior attending physician in the department of internal medicine, and chief of the division of metabolic diseases at Montefiore Hospital. He is survived by his wife, a daughter, and a son, David Odle, M.D.

• **Richard S. Osenkop**, Norristown; Cornell University Medical College, 1943; age 58; died July 15, 1976. He was chief of urology at Phoenixville Hospital. He was affiliated with Montgomery Hospital, Norristown, and North Penn Hospital, Lansdale. A brother survives him.

• **John L. Polcyn**, Lancaster; Western Reserve University School of Medicine, 1946; age 53; died July 26, 1976. He was on the staffs of St. Joseph and Lancaster General Hospitals. He was a member of the American Association of Neurosurgeons, the Congress of Neurologic Surgeons, and the Mid-Atlantic Neurosurgical Society. His wife, two daughters, and a son survive him.

• **Edward J. Zamborsky**, Allentown; Hahnemann Medical College, 1936; age 68; died August 4, 1976. He was a member of the Sacred Heart Hospital medical staff. He was an associate fellow of the American Proctologic Society, a diplomate of the International Board of Proctology, and a fellow of the American Geriatrics Society. His wife, a daughter, three sons, two sisters, and a brother survive him.

Joseph F. X. Bastiampillai, Coraopolis; University of Ceylon, 1951; age 54; died July 3, 1976. His wife and three children survive him.

Hugh J. Burns, Scott Township; Hahnemann Medical College; age 62; died July 31, 1976. He is survived by his wife, three sons, and one daughter.

Society's legislative action subject of Council Report

During the 1975-76 legislative years the Society had "an active interest" in 42 bills in 29 categories, according to the Council on Governmental Relations' supplemental report to the 1976 House of Delegates. Although medical liability insurance received the most extensive coverage by the Society's and other publications, the Society has given other legislative issues the attention which they have merited.

At the writing of the report, the State Legislature was in recess until September 20, is due to recess again several weeks prior to the general election, and is bound by law to adjourn by November 30. As a result, the supplemental report "cannot be considered the final history of medical legislation . . . but it is probably at least 90 percent final."

Following is a brief summary of the House and Senate bills, besides Act 111 and its amendments, which have become laws during the 160th regular session.

Anatomical gifts—H-1817. The bill is a codification of the Pennsylvania Motor Vehicle Code. It includes a provision, vigorously backed by the Pennsylvania Medical Society Auxiliary, that a driver may affix to his license his Anatomical Donor Card. The bill has become Act 81 of 1976.

Battered children—S-25. The Society Auxiliary was among the strongest supporters of the measure to more effectively protect children from abuse. It became Act 124 of 1975.

Child health—S-120. Now Act 81 of 1975, the measure requires health insurance policies to provide coverage for newborn children.

Immunization programs, legal protection—H-2354. According to the bill which is now Act 187 of

1976, physicians and nurses have legal protection when participating in state-approved mass immunization programs. State, county, and local medical societies are mentioned specifically in the protection clause.

Reform of payment methods for medical assistance—H-694. The bill, called "welfare reform" permits the Department of Public Welfare to prepay or contract for insurance coverage for medical assistance recipients.

Deficiency appropriation for medical assistance—H-78. The Society and the Hospital Association of Pennsylvania strongly supported the bill to provide a \$31 million deficiency appropriation for fiscal 1976. If it had not passed, hospitals and physicians would not have received payment for medical assistance services.

Mental health, common commitment—S-1025. Now Act 143 of 1976, the "Mental Health Procedures Act" received backing from the Pennsylvania Psychiatric Society which was instrumental in designing many of the provisions. The Society also supported the measure until the House amended the bill to allow psychologists to have equal status with psychiatrists under certain circumstances.

Heads of mental health programs—H-45. The bill is an amendment to the "Mental Health and Mental Retardation Act of 1966" and reduces the requirement that heads of mental health programs must be physicians. Through Society efforts, the measure, now Act 46 of 1975, contains language requiring the Department of Public Welfare to look for a physician first before choosing a layperson.

T.V. picture tubes—H-449. The bill became Act 74 of 1976 and requires that television picture

tubes be neutralized before they are discarded.

In addition to the above bills, the House passed H-Res. 131, in which the Society has had special interest, requiring the House Committee on Health and Welfare to investigate the Department of Public Welfare's medicaid reimbursement system. The committee has held hearings at which the State Society and some county medical societies testified.

Bills which were still in committee at the writing of the supplemental report follow.

Acupuncture—H-834. The bill would give the State Board of Medical Education and Licensure the authority over rules and regulations concerning the use of acupuncture. Legislative urgency was lost after the attorney general handed down an opinion giving physicians, dentists, podiatrists, and veterinarians exclusive use of acupuncture and specifically denying optometrists and chiropractors its use.

Audiologists—S-1344 and S-1345. The bills would create a state board to license audiologists and speech pathologists and have been opposed by the Pennsylvania Academy of Ophthalmology and Otolaryngology.

Ambulances—S-46 and H-728. The bills contain measures to regulate and upgrade the state's volunteer ambulance corps. Each bill has passed its originating chamber but the House recently defeated S-46. It has been replaced on the House calendar to be reconsidered when the Legislature returns.

Chiropractors—H-1044 and H-1883. H-1044 would make chiropractic services available under the Workmen's Compensation program. Passed by the

House, it is currently tabled in the Senate Labor Committee. H-1883 would place chiropractic services under the Blue Shield Plan. It was defeated in the Senate by a vote of 28 to 18. There was a motion for reconsideration and currently the bill is in the Senate State Government Committee.

Child health—S-117 through S-119, and S-121. Each bill would affect the health of infants and in some instances have been recommended by certain pediatric groups. Among other things, they would require marriage license applicants to be examined for immunity to rubella, require premarital serologic testing for carriers of other genetic diseases, and set up regional newborn special care centers throughout the State.

Comprehensive Health Planning—S-10, H-853, and H-2293. The three bills are similar, require most State medical facilities to obtain "certificate of need" permits before expansion, and require various kinds of reports from hospitals and in-hospital practitioners. None of the bills has passed its originating chamber.

Conflict of interest—S-169. According to S-169 it is a misdemeanor to sit on a hospital board and have a financial interest through the sale of goods or services to that hospital. The measure passed the Senate but has been in the House Judiciary Committee since April 1975.

Death—H-363 and H-2310. The bill would provide a statutory definition of death. The Society is strongly opposed to such a definition and testified to that effect before the House Judiciary Committee where the bill remains. H-2310 regards the "living will" permitting a person to signify before the onset of illness that he does not want his life prolonged through heroic measures. The bill remains in the Judiciary Committee.

Disease Reporting—H-1434. Currently in the House Committee on Health and Welfare, the bill would amend the "Disease Prevention and Control Law of 1955" to include as reportable diseases malignant neoplasms and cardiovascular diseases.

Emergency medical systems—H-1603. Complementary to S-46 and H-728, the bill would permit the Commonwealth to encourage, through loans and technical help, the development of comprehensive area emergency medical service systems.

Generic prescriptions—H-473. The bill would permit pharmacists to fill prescriptions generically if the patient requests it and the physician permits it on the prescription. It contains language which gives the physician power over the disposition of the prescription and for that reason the Society has not opposed the bill. It has passed the House and is before the Senate Public Health and Welfare Committee.

Hearing aids—H-1880. The Pennsylvania Academy of Ophthalmology and Otolaryngology has cooperated in the design of the bill to regulate persons who sell hearing aids.

Medical and personal information—H-11. The so-called "Fair Information Practices Act," the measure is an attempt at tightening up the amount of medical, personal, financial, and other types of private information available to outside sources. Watched closely by the Society, it remains in the House Judiciary Committee where members are having difficulty in the bill's final design.

Laboratories, physicians' offices exempt—S-1304. The bill was introduced through Society efforts and is an attempt to reinstate in the "Clinical Laboratories Act" the exemption for a physician's office laboratory op-

erated solely for the physician's own patients. At this writing the bill is in the Senate Committee on Public Health and Welfare.

Medical education—H-545 and H-546. The bills are the "Pennsylvania Medical Education Council" and the "Pennsylvania Medical District" bills. Both have passed the House but are before several Senate committees from which they are not expected to emerge.

Cost of medical licensure—H-2422. Introduced by the Administration, the measure would increase the biennial costs of all professional and occupational licenses. It stipulates a \$50 biennial cost for renewal of a medical license. The measure contains a provision that the State Board of Medical Education and Licensure retain all its fees.

Physicians' office locations in medical schools—H-251. The bill prohibits private physicians from having office space in medical schools. It remains in the House Committee on Professional Licensure.

Foreign trained medical students—H-1976. The measure incorporates the "Fifth Pathway Program" to accommodate American born, foreign trained students returning for clinical work in Pennsylvania medical schools. The Society has supported the bill, which has passed the House and is currently before the Senate Committee on Education.

Physicians' assistants—S-306 and H-1643. The two bills would require the State Board of Medical Education and Licensure to regulate the practice and training of physicians' assistants. S-306 has passed the Senate and is currently before the House Committee on Professional Licensure. At this writing, the Society is making an effort to have the bill released from committee for a vote prior to adjournment.

AMA session to study pollution impact on patients

The American Medical Association's Department of Environmental, Public, and Occupational Health plans to conduct a continuing education course, entitled "Air Pollution and Patient Management," December 3, in the Philadelphia Civic Center.

The course will offer information on the types of illnesses that may be related to air pollution with emphasis on treatment for patients who are particularly susceptible to health problems from airborne materials. Use of materials and tests to determine the extent of air pollution in a given area will be demonstrated.

Lecture topics will include the nature of air pollution in the United States, air pollution and pulmonary physiology, sulfates and particulates, and oxides of

nitrogen and carbon monoxide.

The course is acceptable for Category I credit for the AMA's Physician's Recognition Award. The registration fee is \$25. Additional information and an

advance copy of the program is available from the AMA Department of Environmental, Public, and Occupational Health, 535 North Dearborn St. Chicago, IL 60610.

Consumer health role program subject

Pennsylvania Hospital has developed a program, with the help of a \$55,400 grant from the William Penn Foundation, for consumer health education as a way to combat rising health care costs.

Hospital president H. Robert Cathcart explains, "It is our belief that individuals who are knowledgeable about their health and how to maintain it will stay healthier, require fewer health services, and thereby reduce the

demand on an overburdened system."

The hospital has begun work on an education and exhibit center which will offer various programs aimed at its inpatients, its community, visitors, and employees.

An extensive repertoire of lectures, audio-visual presentations, and management training sessions for staff will be utilized in the educative series, which is expected to be underway by early 1977.

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S-3.	6	60	_____	_____	_____	_____
S-4.	6	60	_____	_____	_____	_____
S-5.	3	30	_____	_____	_____	_____

S-6.	3	30	_____
S-7.	5	50	_____
S-8.	3	30	_____
S-9.	3	30	_____
S-10.	3	30	_____
S-11.	11	130	_____
S-12.	6	60	_____
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In Category 1, you can choose from 46 postgraduate courses, 9 general sessions, telecourses, living teaching demonstrations, and conducted exhibit rounds. In addition, Category 2 credits can be obtained by paid attendance at 16 luncheon and 32 "Meet the Professor" sessions.

Plan Now for Your CME in Philadelphia • Use the coupon to register now for the postgraduate courses of your choice. The complete selection and full descriptions of the over 103 CME events will be available in the October 11, 1976, Clinical Convention Issue of the **Journal of the American Medical Association (JAMA)**. You may also check the coupon box to receive the AMA's Philadelphia Clinical Convention Brochure which has material similar to the JAMA Convention Issue. After filling in information, send this coupon to the AMA with your accompanying check or money order. Advance registration requests must be received by October 29, 1976. Course tickets and registration

The Bicentennial City • It is particularly appropriate in this Bicentennial Year that Philadelphia be the site of AMA's 30th Clinical Convention. Because Philadelphia is not only the birthplace of our Nation, but it can also lay legitimate claim to being the cradle of American medicine. It is the site of the first hospital, the first medical school, and the home of many famous American Colonial physicians, such as Benjamin Rush, John Shippen, and John Morgan.

In your off hours, you can step back into history with visits to Independence Hall, the new Liberty Bell Pavilion, Betsy Ross' House, the Franklin Institute, and many other historical sites. For all of its historical significance, Philadelphia is as modern and sophisticated a city as there is. There's a multitude of superb restaurants to delight the gourmet, including the Old Original Bookbinder's.

materials will be sent to you on November 12, 1976. All tickets requested after that deadline date will be held for pickup at the Postgraduate Registration Desk in the Philadelphia Civic Center.

If the minimum course registration is not attained for your first choice, or if the course is full, one of your alternate choices will be substituted. It is best to register early because the class sizes are limited. All medical students, interns, and residents are entitled to a 50% discount on postgraduate course fees (\$10 per Category 1 credit hour is standard rate).

Postgraduate Courses

Saturday, Dec. 4, 1976

7:30 AM-Noon (5 hours: \$50)

- *S-1. Basic Life Support (Cardiopulmonary Resuscitation—CPR)

9:00 AM-5:30 PM (6 hours: \$60)

- S-2. Practice Management Seminar
- S-3. Writing for Scientific Journals
- *S-4. Nutrition: Parenteral & Alimentary

9:00 AM-Noon (3 hours: \$30 each)

- *S-5. Basic Electrocardiography
- S-6. Evaluation of the Dizzy Patient

1:00-5:30 PM (5 hours: \$50)

- S-7. Basic Life Support (CPR)

2:30-5:30 PM (3 hours: \$30 each)

- S-8. Hematologic Disorders in Children
- S-9. The Eye & Office Practice
- S-10. Coronary Artery Disease: Medical vs Surgical Therapy

Sat., Dec. 4 & Sun., Dec. 5

9:00 AM-5:30 PM & 9:00 AM-Noon (11 hours: \$110, plus \$20 lab fee = \$130)

- S-11. Public Speaking Seminar
- 9:00 AM-Noon & 9:00 AM-Noon (6 hours: \$60 each)
- *S-12. Fluid & Electrolyte Therapy
- S-13. Diseases of the Bowel
- S-14. Arthritis Update: Medical & Surgical Management
- 2:30-5:30 PM & 2:30-5:30 PM (6 hours: \$60 each)
- *S-15. Management of Diabetes Mellitus
- S-16. Hypertension

Sunday, Dec. 5, 1976

9:00 AM-Noon (3 hours: \$30 each)

- S-17. Diagnosis & Treatment of Fractures of the Upper Extremities
- *S-18. Advanced Electrocardiography
- S-19. Emergency Medicine
- 2:30-5:30 PM (3 hours: \$30 each)
- *S-20. Pulmonary Function & Blood Gases
- S-21. Behavioral Problems Involving Children & Adolescents
- S-22. Recent Advances in Cancer Surgery

Sun., Dec. 5 & Mon., Dec. 6

7:30 AM-5:30 PM & 7:30 AM-Noon (12 hours: \$120)

- S-23. Advanced Life Support (CPR)

9:00 AM-Noon & 9:00 AM-Noon (6 hours: \$60)

- S-24. Jaundice: Diagnosis, Treatment & Management

2:30-5:30 PM & 9:00 AM-Noon (6 hours: \$60)

- S-25. Everything You Want to Know About New Diagnostic Techniques: Scoping, Scanning, & Angiography

Monday, Dec. 6, 1976

9:00 AM-Noon (3 hours: \$30 each)

- S-26. Diagnosis & Treatment of Fractures of the Lower Extremities
- S-27. Neonatology
- S-28. Current Controversies in Gynecology

2:30-5:30 PM (3 hours: \$30 each)

- S-29. Basic Electrocardiography
- S-30. Pulmonary Function & Blood Gases
- *S-31. Complications of Psychotropic Drugs

Mon., Dec. 6 & Tues., Dec. 7

9:00 AM-Noon & 9:00 AM-Noon (6 hours: \$60 each)

- S-32. Immunology 1976
- S-33. Thromboembolism: Prevention, Diagnosis, & Treatment

2:30-5:30 PM & 2:30-5:30 PM (6 hours: \$60 each)

- S-34. Fluid & Electrolyte Therapy
- S-35. Nutrition: Parenteral & Alimentary
- S-36. Management of Diabetes Mellitus

Tuesday, Dec. 7, 1976

7:30 AM-Noon (5 hours: \$50)

- S-37. Basic Life Support (CPR)
- 9:00 AM-Noon (3 hours: \$30 each)
- S-38. Diagnosis & Treatment of Fractures in Children
- *S-39. Dermatology for the Nondermatologist

- S-40. Allergic Emergencies
- S-41. Medical Problems in Long-Term Care
- S-42. Acute Hand Problems

1:00-5:30 PM (5 hours: \$50)

- S-43. Basic Life Support (CPR)

2:30-5:30 PM (3 hours: \$30 each)

- S-44. Advanced Electrocardiography
- S-45. Dermatology for the Nondermatologist
- S-46. Complications of Psychotropic Drugs

*Course repeated. See course list for dates & times.

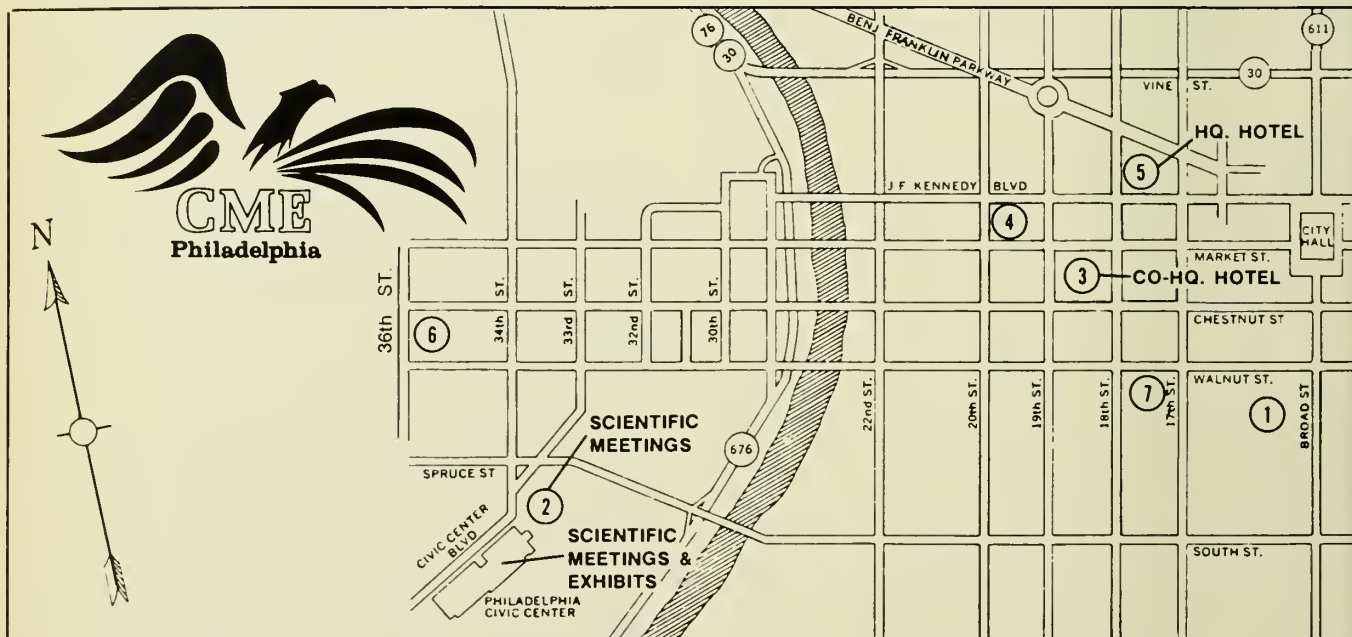
30th AMA Clinical Convention December 4-7, 1976 • Philadelphia, Pa.

Housing Form



Key #	Hotel/Motel	Single	Double	Twin	Suite
1.	Bellevue Stratford	\$27.00-40.00	\$34.00-47.00	\$34.00-47.00	\$ 60.00-105.00 (1 Bedroom) 107.00-152.00 (2 Bedrooms)
2.	Hilton of Philadelphia	30.00-40.00	40.00-50.00	40.00-50.00	110.00-190.00 (1 Bedroom) 160.00-250.00 (2 Bedrooms)
3.	Holiday Inn — Center City	CO-HEADQUARTERS HOTEL		NO ROOMS AVAILABLE	
4.	Penn Center Inn	25.00-27.00	30.00-32.00	30.00-32.00	60.00 (1 Bedroom) 90.00 (2 Bedrooms)
5.	Philadelphia Sheraton	HEADQUARTERS HOTEL		NO ROOMS AVAILABLE	
6.	University City-Holiday Inn	29.00	36.00	36.00	95.00-105.00 (1 Bedroom)
7.	Warwick Hotel	32.00-38.00	38.00-44.00	38.00-44.00	75.00-100.00 (1 Bedroom) 100.00-150.00 (2 Bedrooms)

THE ABOVE RATES ARE SUBJECT TO A 6% HOUSE OCCUPANCY TAX.



American Medical Association's 1976
Philadelphia Clinical Convention

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FOR ROOM RESERVATIONS

Please print or type four choices:

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- _____
- _____
- _____

Please enter my reservation at the above hotel/motel for:

Single(s) _____ Double(s) _____
at \$ _____ at \$ _____
Twin(s) _____
at \$ _____
Suite(s) _____
1 Bedroom _____ 2 Bedroom _____
at \$ _____ at \$ _____

Please add 6% for the House Occupancy Tax; if your rate requested is not available, the next highest rate will be assigned. **DO NOT** send your request directly to the hotel; it will only delay your confirmation. Kindly make all necessary changes and cancellations directly with the Housing Bureau in Philadelphia, and be sure and specify your time of arrival, as well as the date. If you are an Industrial Exhibitor, please specify your firm's name and the list of all the occupants for all the rooms that you are reserving.

CONFIRMATIONS WILL BE MAILED UP TO NOVEMBER 12, 1976.

Room will be occupied by:

Name _____ (Please print or type.)

Firm _____

Address _____

City/State/Zip Code _____

Office Phone Number () _____ - _____

Additional Occupants (List ages of children, if any): _____

Arrival Date _____ at _____ AM, PM, Departure Date _____

Award bestowal kindles memory

GEORGE E. FARRAR, JR., M.D.

New Hope

Dr. Farrar received a 1975 Strittmatter Award, along with Harold G. Scheie, M.D., from the Philadelphia County Medical Society in May. An account of the accomplishments of Drs. Farrar and Scheie appeared in the September issue of PENNSYLVANIA MEDICINE. Dr. Farrar's comments upon receipt of the award follow.

Shortly after President Perloff [Milton M. Perloff, M.D., president of the Philadelphia County Medical Society] notified me of my selection to share the Strittmatter Award in 1976 with our distinguished colleague Dr. Harold Scheie, the quotation of the day in the *New York Times* (May 4, 1976) read:

"I think I should accept it in dignified silence and say nothing. Of course, I'm pleased, tickled and amused."—Saul Bellow, Pulitzer Prize winner for *Humboldt's Gift* after being reminded that he had a character in an earlier novel say that 'Pulitzer is for the birds—for the pullets.' "

How appropriate! I never made jokes about Dr. Strittmatter, but I have been consistently critical of the performance of organized medicine. I always wanted the medical profession, excellent as it is in our civilization, to be "even gooder." It is fortunate for me that, continuously for twenty years, you have rewarded my interest and industry with elective offices. This experience has shaped and embellished my life; I thank you.

What did I do for the Philadelphia County Medical Society? Memories of several major projects in medicine in which I participated with many of you here tonight rush through my mind.

Then I wonder, why did Dr. Strittmatter establish this trust fund in 1923? The official records of the society record the gift and its implementation over the fifty years but not the reason or the hope—the dream, the purpose—for this award. Why did a general practitioner at Fifth and Girard, riding a bicycle for his house calls, make such a bequest? What did he have in mind?

Dr. Richard A. Kern, one of the recipients of the Strittmatter Award, remembers Dr. Strittmatter as an active Catholic layman at St. Peter's. In 1923 the war was over. America was in a fantastic boom. It was the age of "flappers," the Charleston, short skirts, short hair. I graduated from high school (the Pennington School in New Jersey which I often pass in commut-

ing to Princeton fifty years later). The medical society rented a one room office. In 1924 the well known surgeon, Dr. W. W. Keen, gave a series of radio talks on the medical profession. In 1925, our historian Dr. James B. Anders broadcast a history of the county society and the home at Twenty-first and Spruce Streets was purchased. In 1926, an auditorium was built in the backyard of the home. Clearly, organized medicine was seeking public recognition and support for improved public health in Philadelphia.

At the College of Physicians of Philadelphia, Mrs. Gartrell found the remarks of Dr. I. P. Strittmatter in presenting his award for 1932 to Dr. Lawrence F. Flick in recognition of his accomplishments with tuberculosis. Dr. Strittmatter said, "When, early in 1923, the thought arose of establishing a fund for the purpose of stimulating and distinguishing idealistic devotion and labor in the medical profession by an annual award, the conviction came that there was no more representative body of men in America than the Philadelphia County Medical Society to carry out that purpose . . . Let us hope that the rapidly improving spirit and splendid cooperation developed in our county medical society, will in the years to come be a beacon light, not only to its members, but likewise to the whole medical world."

My memory of projects I did with you consists mainly of public relations activities which I believe Dr. Strittmatter had hoped to stimulate. They include:

1. The move of the society to this edifice at Twenty-first and Spring Garden Streets; as treasurer at the time, the financing was my duty.
2. The successful mass Sabin poliomyelitis immunization program organized and conducted by the county medical society with Dr. Francis Sweeney, chairman of the Committee on Public Health.
3. The acquisition of the Pfahler Foundation fund for educational loans.
4. The five years it was my privilege to represent organized medicine on the Executive Committee of the United Fund of Greater Philadelphia. Lay leaders need and want advice on health problems. They accept advice better from friends than from strangers, and they are fine people.
5. The three years I served you as president (presi-

dent elect and past president) of the Pennsylvania Medical Society during which time constructive leadership was provided to a changing civilization, such as the Pennsylvania Medical Care Foundation under the leadership of Dr. Matthew Marshall, of Pittsburgh, and now Dr. Sidney O. Krasnoff, of Philadelphia; the program for continuing medical education of all our members; the Interspecialty Committee which grew into the acceptance of specialty delegates into the House of Delegates of the State Society; the organization of a Commission on Therapeutics, etc.

6. Finally, the active effort of many of you here tonight in the reorganization of the north branch of the county medical society. In the 1950s the failure of grass roots participation in the society caused an attempt to rejuvenate the branches. You can't fit 3,000 members into this auditorium.

The first meeting to approve the building of this edifice failed to bring a quorum (only 50 members). In the eighteenth century Benjamin Rush and his colleagues met every Saturday at 6:00 p.m. to present and debate their observations. Did yellow fever come with the windjammers or was it indigenous? As people died and U.S. Government offices were moved to tents along the Schuylkill River, the debate was violent—verbally, physically, and legally! But, who ever considered the mosquito?

I urge all members to be active in a local medical group, such as your branch society, your hospital staff, your specialty society chapter. They have enriched my life; I believe you will benefit, and I am sure that our citizens will be better served.

Presently we are sorely troubled with medical liability problems and mushrooming governmental surveillance. To obstruct ill-conceived schemes for medical care is our duty as physicians, but the only real relief is an effective program.

Patton's tanks, not the Maginot line, won World War II. The problems of a mass "Swine Influenza" immunization program are about to explode all over you. If this fizzles, who will blame President Gerald Ford?

To me the most important issue is the difficulty experienced by the public in finding medical care. You take fine care of *your* patients, but many people have no physician. They phone from the Yellow Pages. "The doctor doesn't take new patients," or "The first appointment is 4 weeks from Tuesday at 7 a.m." are the replies. What does an uncomfortable and frightened human being do? Ladies and gentlemen, if you don't solve this public relations problem, inexperienced Congressmen may pass silly laws to regulate health care.

Thanks for your many kindnesses to me. Best wishes to you all.

**You are cordially invited
to attend the
Fourth Annual Prayer Breakfast
of the
Committee on Medicine, Religion, and Bioethics
Pennsylvania Medical Society
Speaker: Dr. William Barr Oglesby
Professor of Pastoral Counseling
Union Theological Seminary, Richmond, Virginia
Topic: Pastoral Counseling in the Light of
New Medical Technology
8 a.m., Thursday, November 4, 1976
Hershey Motor Lodge, Hershey**

\$5.00 per person. Please make checks payable to the Pennsylvania Medical Society and forward to Kay Mundis at Society Headquarters. Deadline for reservations is October 25, 1976.

Pennsylvania Medicine

NOVEMBER 1976

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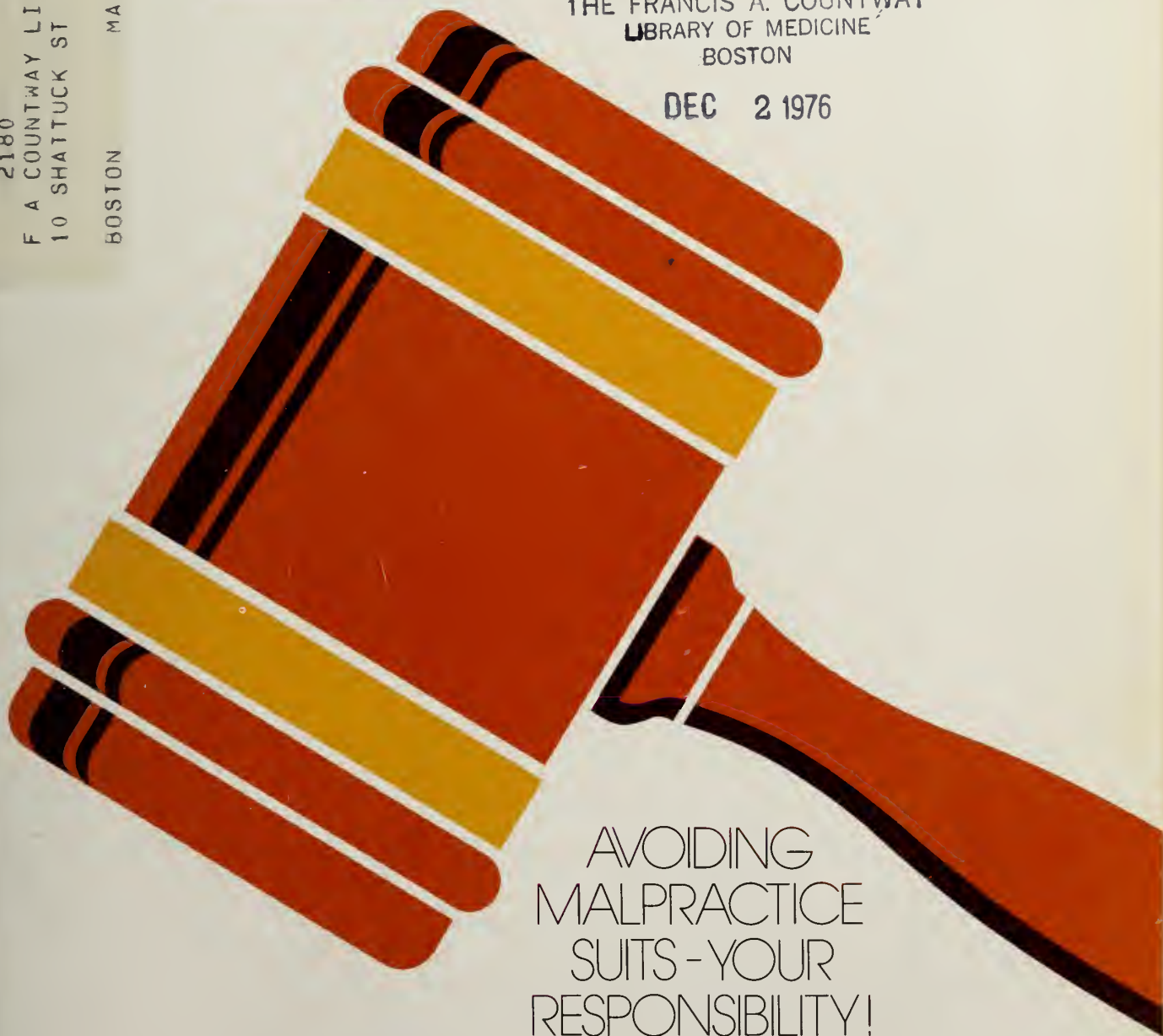
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MEMBERSHIP APPLICATION

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☐ I have heard enough. I am a member of the Pennsylvania Medical Society, so please enroll me as a member of the Pennsylvania Medical Cooperative. Enclosed you will find a check in the amount of \$200 to cover the membership requirement. It is my understanding that this is a life-time subscription entitling me to a vote in the affairs of the Cooperative and giving me the right to purchase all medical supplies offered by the Cooperative.

☐ I am impressed by what I have read, but I would like to know more. Please send me more information and a membership application on the Co-op.
(Please make checks payable to the Pennsylvania Medical Cooperative.)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone number: _____

Another member benefit of the Pennsylvania Medical Society!

ARGONAUT SEEKS RECONSIDERATION OF RATE INCREASE

Argonaut Insurance Co.

reconsideration of its 42 percent rate increase request on October 29. Insurance Commissioner William J. Sheppard has 30 days to act by either granting the request, denying it, or scheduling new hearings. Otherwise his original rejection is deemed in effect. Argonaut also seeks to cancel five policies by January 1, 1977. Acting under the October 5 court order of Judge Stanley M. Greenberg of Philadelphia Common Pleas Court, the Commission on Professional Liability Insurance will meet November 17 to consider the cancellations. Appeals go to Judge Greenberg. See page 2 for details.

THE FRANKS COUNTYWAY
DEPT OF MEDICINE
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DEC 2 1976

AMA CLINICAL MEETING IN PHILADELPHIA

Pennsylvania is the host state to

the AMA's Clinical Convention, which opens in Philadelphia December 4. Pennsylvania delegates on reference committees are Malcolm W. Miller, M.D., chairman of the Pennsylvania Delegation, and Edmund L. Housel, M.D., delegation secretary. Dr. Miller will serve on the reference committee on medical education, and Dr. Housel is chairman of one of two reference committees on miscellaneous items. Other Pennsylvanians in leadership roles are: William Y. Rial, M.D., vice speaker of the House of Delegates; Richard M. Bergland, M.D., member of the Council on Continuing Physician Education; Paul S. Friedman, M.D., member of the Council on Legislation; and James B. Snow, M.D., member of the Council on Scientific Affairs. R. Robert Tyson, M.D., of Philadelphia, is program chairman of the Clinical Convention. See page 13 for details.

DR. RIAL CANDIDATE FOR SPEAKER OF AMA HOUSE

William Y. Rial, M.D., of Swarthmore currently vice

speaker of the AMA House of Delegates and former speaker of the PMS House, is a candidate for speaker of the AMA House. The family physician's candidacy was announced by the Pennsylvania Delegation to the AMA. Elections will be held at the June 1977 Annual Session of the American Medical Association in San Francisco.

NEW COUNCIL CHAIRMAN NAMED

Michael P. Levis, M.D., past president of the Allegheny County Medical Society and a

member of the Board of Directors of the American Medical Association Political Action Committee, has been appointed chairman of the Society's Council on Governmental Relations. He succeeds Donald E. Harrop, M.D., of Phoenixville, who was elected vice speaker of the House of Delegates in September.

HSA 'GET ACQUAINTED' SESSIONS PLANNED

The Commission on Health

Planning is sponsoring a series of meetings of county medical society representatives and physician members of Health Systems Agency governing boards in the following Health Service Areas: HSA 7, Erie, November 3; HSA 2, Wescosville, November 10; HSA 5, Lewisburg, November 17; and HSA 6, Pittsburgh, December 2. Call Dale Yates at Society Headquarters (717-238-1635) for further information. The AMA Council on Medical Service has scheduled a conference designed to give to physicians a general understanding of the federal health planning law (P.L. 93-641) in conjunction with the AMA Clinical Convention. The meeting, cosponsored by the Pennsylvania Medical Society, will be held from 1 to 4 p.m., Saturday, December 4, in Ballroom A of the Philadelphia Civic Center. Those attending can earn three hours of Category I credit toward the Physician's Recognition Award.

MOST MEET CONTINUING EDUCATION REQUIREMENT

With two months remaining to file reports, only 781

members of the Pennsylvania Medical Society have not yet submitted evidence of compliance. They have been notified that they face suspension unless they submit evidence of continuing education activities during the past three years. Executive Vice President John F. Rineman, in accordance with the Constitution and Bylaws, mailed individual letters October 29, urging that reports be submitted immediately. Deadline for reporting is December 31, 1976. The letter referred questions and problems to the Society's Continuing Education Center, 20 Erford Road, Lemoyne, PA 17043, or telephone (717) 238-1635.

MEDICAL ARTS '76 MARKED BY VARIETY

The State Society's educational assembly, Medical Arts '76, is in progress at Hershey Motor Lodge November 3-5, attracting a variety of health professionals from throughout the state. Meetings of the Pennsylvania Association for Medical Education, the Pennsylvania Council of Health Professionals, the Pennsylvania Society-American Association of Medical Assistants, and a number of specialty societies are being held as part of the assembly. The Society's Commission on Accreditation and the Executive Committee of the Council on Education and Science are meeting during the session. The Committee on Medicine, Religion, and Bioethics is holding its annual prayer breakfast during the assembly. Medical Arts '77, now being planned, will include the AMA's 1977 regional continuing medical education meeting.

PROVIDER ABUSE OF MEDICAID HIT

The Department of Health, Education, and Welfare has issued a flat prohibition against the practice of some physicians and dentists of selling medicaid accounts due them to a private collection or service agency. Part of an intensive effort to cut costs in the medicaid program, which costs \$16.5 billion annually, the action was taken because of allegations of improper activities by such agencies, including submitting inflated bills. Power of attorney arrangements under which a check is payable to a provider but can be cashed by a factor also are prohibited. Bona fide business agents, accounting firms, and billing agents are not included. See page 16 for further details.

STATE GOVERNMENT BUREAU FOSTERS MALPRACTICE SUITS

Society President William J. Kelly, M.D., has sent a strongly worded protest to Edward W. Robinson, Jr., state commissioner for professional and occupational affairs, on the publication of an article in Bureau of Professional and Occupational Affairs employees' newsletter which encourages malpractice suits. The newsletter article likens professional liability insurance to workers compensation, and says: "Don't be afraid to sue. An arbitration board has been set up, and the insurance we are requiring for the doctor or hospital to carry will cover you." Dr. Kelly said in his letter, "It's pure irony that the bureau that administers the State Board of Medical Education and Licensure should be the source of this uninformed newsletter item." Copies of the letter went to Governor Milton J. Shapp, Secretary of the Commonwealth C. Delores Tucker, Secretary of Health Leonard Bachman, M.D., and other elected and appointed officials.

NAIC SAYS STATE TENTH IN MALPRACTICE INCIDENCE

The National Association of Insurance Commissioners lists Pennsylvania tenth of all the states in malpractice incidence. There are an average of three claims per hundred physicians in the Commonwealth compared with Alabama's 6.4, California's 4.5, New York's 2.2, New Jersey's 1.6, and Massachusetts' 0.7.

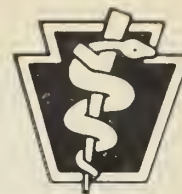
FOUNDATION ELECTS OFFICERS

The Pennsylvania Medical Care Foundation elected officers and six members of the Board of Directors October 24. Sidney O. Krasnoff, M.D., of Philadelphia, was re-elected president. Re-elected with him were: Joseph N. Demko, M.D., of Scranton, as vice president; Robert A. Albright, of Pittsburgh, as secretary; and John F. Rineman, the Society's executive vice president, as treasurer. Robert P. Dutlinger, M.D., and George Schmitt are new members of the Board of Directors. Re-elected Board members are: Vincent Lechner, John E. McGrady, Jr., Albert W. Speth, and Robert B. Edmiston, M.D.

MONOVALENT VACCINE AVAILABLE TO PHYSICIANS

Robert D. Gens, M.D., director of adult health services for the Department of Health has said that November 9 is the date monovalent A/New Jersey vaccine will be provided to individual physicians in batches of 50 doses. Physicians in the 65 counties in the Pennsylvania Department of Health immunization program are to apply at their county health offices, using the form which appeared in the September issue of PENNSYLVANIA MEDICINE. Dr. Gens also said that well adults over age 55 may be given the bivalent vaccine, a combination of A/New Jersey and A/Victoria. At this writing, no recommendations have been received from the U.S. Public Health Service on influenza immunization for children under 18.

Pennsylvania Medicine



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November 1976

Volume 79, Number 11

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PENNSYLVANIA MEDICINE

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Insurance Department denies Argonaut rate increase

Argonaut Insurance Company's request for a 42 percent rate increase in professional liability insurance premiums was denied October 14 by Insurance Commissioner William J. Sheppard, who termed the request "excessive."

The decision directly affects more than 4,200 State Society members who are insured by Argonaut, saving them a minimum of \$7 million in increased premiums for the first year.

Argonaut filed for the rate increase on March 11, 1976. During spring hearings, the State Society and other parties objected to the filing and the validity of Argonaut's calculations. Later the company attempted to put the rates into effect without approval by using the insurance law's deemer clause, which says that if the department has not ruled on a rate filing within 60 days, the company may "deem" the new rates to be in effect. The State Society immediately filed a complaint with the department blocking the action.

In handing down his decision Sheppard said his department's extensive examination of the filing disclosed that Argonaut had substantially overstated the reserves allotted for payment of Pennsylvania claims. He said this overstating impacted on the filing in a manner which indicated a need for rates higher than are actually called for.

Earlier in the month in Philadelphia Judge Stanley Greenberg, acting on a PMS legal request, ruled that Argonaut must abide by the terms of its contract with the Society with minimum modifications, at least until the

end of the year. The modifications provide that the Commission on Professional Liability Insurance must render a decision regarding appeals on non-renewals or new applications within 20 days after having been requested to do so. The agreement specifies 60 days. Any appeals from the decision of

the commission will be heard by Judge Greenberg who will attempt to resolve the problem within seven days.

In the case of the \$25 million Argonaut suit against State Society in Federal Court, depositions are being taken with trial expected before Christmas.

Dermatologists elect

Charles H. Greenbaum, M.D., F.A.C.P., clinical associate professor of dermatology for Jefferson Medical College, Thomas Jefferson University, has been elected president of the Pennsylvania Academy of Dermatology.

A member of the Board of Directors of the Philadelphia County Medical Society, Dr. Greenbaum serves as president

of the Philadelphia Dermatological Society and chairman of the Advisory Board Council of the American Academy of Dermatology.

Other officers elected were: Marshall Guthrie, M.D., F.A.C.P.,

M.D. registration due

The State Board of Medical Education and Licensure will mail in mid-November biennial registration forms to all M.D.s holding a Pennsylvania license to practice medicine.

Dorothy Bupp, secretary to the state board, urges all physicians to check to make sure they have a current registration and that the board has a current address, so that the registration form reaches them.

The registration form along with the fee of \$75. must be returned to the State Board of Medical Education and Licensure by December 31, 1976.

Physicians who have moved since the 1974 registration or who have any questions may contact the board at 279 Boas St., Harrisburg, PA 17102.



DR. GREENBAUM

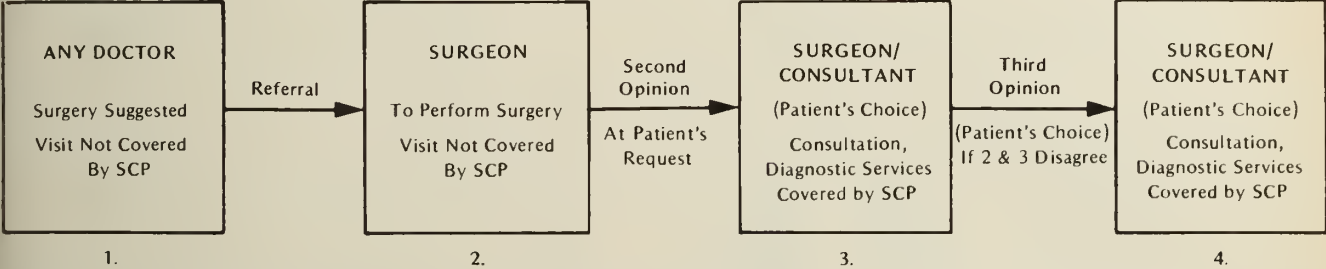
vice president; and Joseph A. Witkowski, M.D., F.A.C.P., secretary treasurer. Dr. Guthrie is an associate in dermatology and Dr. Witkowski is assistant professor of dermatology in the Hospital of the University of Pennsylvania.

Blue Shield expands surgery consult plan

Pennsylvania Blue Shield's pilot Surgical Consultation Program (SCP) is being expanded, beginning October 1, to include certain experience rated groups in the Capital Blue Cross area. Originally the program, begun in January 1976, was offered to more than 5,000 employees of

ance Department as well as by Secretary of Health Leonard Bachman, M.D., in testimony at Insurance Department hearings on Blue Shield's 1976 rate increase request. Dr. Bachman called for rapid statewide expansion of the program. The purpose of the program,

of the consultant, the consultation fee will not be paid by Blue Shield or will be deducted from the allowance for surgery. In addition to offering the experimental program to selected, experienced rated groups with prevailing fee coverage in the 19-county Capital Blue Cross



Pennsylvania Blue Shield and Capital Blue Cross and their dependents. The expansion was urged by the Pennsylvania Insur-

Pennsylvania Affiliate announces 1977 leaders

Harry Prystowski, M.D., dean of the Pennsylvania State University College of Medicine and provost of the Milton S. Hershey Medical Center, was named chairman of the State Heart Fund for 1977 during the 27th annual assembly of the American Heart Association, Pennsylvania Affiliate.

Lawrence N. Adler, M.D., director of the Cardiac Rehabilitation Institute of Pittsburgh, was installed as the 27th president of the organization by outgoing president Harry Goldberg, M.D., of Philadelphia.

Other officers of the Affiliate for 1977 are: John S. Chafee, M.D., Erie, president elect; Robert F. Zelis, M.D., Hershey, Joseph M. Young, Monessen, and Anita J. Herbert, Bradford, vice presidents; Mrs. James W. Potter, Warren, chairman of the board of directors; and Will L. Ketner, Harrisburg, chairman elect of the board.

according to Robert B. Edmiston, M.D., Blue Shield executive vice president for professional affairs, is to test the attitude toward and acceptance of such a program by patients and to determine whether second opinions will serve to identify or reduce inappropriate surgery.

The program works in this manner. Under the program, the initial visit to a doctor or a referral to a specialist to have the surgery performed is not covered, as outlined in the example shown. If an employee or dependent wishes a second opinion on the recommended elective surgery, he can ask for a surgical consultation from another physician of his choice. Blue Shield will pay for this consultation and any necessary diagnostic procedures. Additionally, if the two opinions conflict, Blue Shield will pay for the third opinion if requested by the individual. Participation in the program is voluntary and the final decision on the proposed surgery is made by the individual.

A consultant is discouraged from performing the surgery. Should the surgery be performed by the consultant or an associate

area, Blue Shield has included Honeywell Inc., a group of approximately 2,000 subscribers in the Philadelphia area, which began participation in the program July 1, 1976.

When a patient who is covered by this program seeks surgical consultation, he will provide the consultant an information packet containing a specially-marked Doctor's Service Report and Surgical Consultation Report. Personal information obtained from the program will be held in strict confidence, in keeping with customary Blue Shield policy.

Consultant's recommendations will have no effect on the payment of proposed surgery. Blue Cross/Blue Shield benefits will be paid on all surgery performed.

Although the program is being expanded, Blue Shield spokesmen say it could continue as a pilot project for another two to four years until sufficient data for evaluation can be obtained and analyzed.

Blue Shield's surgical consultation project is one of the first in the country. Several other Blue Shield plans are patterning programs after it.

Narrowing down pneumonias

Upjohn

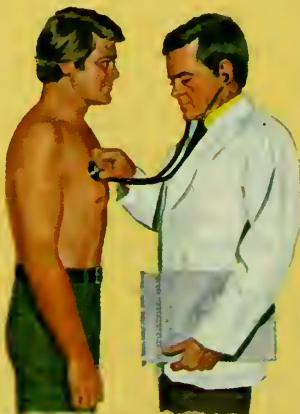
Bacterial or nonbacterial?

In the early stages of mild to moderate pneumonia, it is often difficult to reach an accurate bacteriologic diagnosis. A tentative differentiation may be made on history-taking, physical examination, CBC with differential analysis, and microscopic study of the sputum smear.

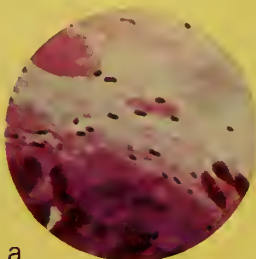
Specimens should be obtained for culture and sensitivity testing, but when a bacterial pneumonia is diagnosed, therapy is often instituted before the etiological agent is positively identified.

Bacterial pneumonias may have a sudden onset with a shaking chill, rapid development of fever, pleuritic pain, and cough productive of rust-colored sputum. The Gram-stained sputum smear generally shows polymorphonuclear neutrophils as well as a predominance of the causative organisms. These are likely to be *Streptococcus pneumoniae*, still by far the most frequently encountered agent in bacterial pneumonia.¹ The CBC reveals marked leukocytosis with a shift to the left.

In **nonbacterial pneumonias**—mycoplasmal or viral—classical symptoms tend to develop more slowly, with myalgia, lassitude, and headache predominating. Sputum production is usually scanty, and the sputum smear is relatively uninformative, showing gram-positive cocci and other organisms which are part of the normal pharyngeal flora. The leukocyte count is normal or slightly elevated.



Direct Gram-stained sputum smears. (a) Pneumococcal pneumonia—note abundant polymorphonuclear leukocytes, as well as gram-positive diplococci. (b) Nonspecific—consistent with viral or mycoplasmal pneumonia. Note large mononuclear cell, as well as a few polymorphs and mixed bacterial flora (pharyngeal contaminants).



a



b

Mycoplasmal or viral?

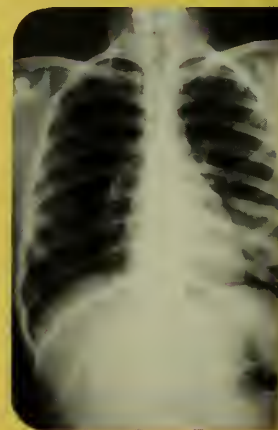
Differentiation between mycoplasmal and viral pneumonias may be impossible in the acute stage.

Serologic testing and culture methods for *Mycoplasma pneumoniae* are complex and time-consuming, taking as long as two weeks after obtaining samples. The sensitivity and specificity of the test for cold agglutinins have been questioned. The complement-fixing antibody test may reflect previous infection. Furthermore, facilities for culturing *M. pneumoniae* are not widely available.³

If treatment is to be initiated, therefore, it may be necessary to start on the basis of a *presumptive* diagnosis of mycoplasmal pneumonia.¹⁻³ In reaching such a diagnosis, the physician relies on clinical judgment, considering such factors as the age of the patient and the history of exposure. For example, *Mycoplasma pneumoniae* is considered the most common cause of pneumonia among ambulatory patients aged 20 to 35.¹

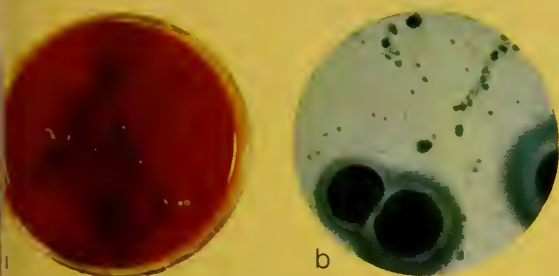


a



b

Chest x-rays of patients with (a) pneumococcal pneumonia—classically heavy, extensive infiltration of left lung; (b) mycoplasmal pneumonia—mild infiltrate confined to left lower lobe. Roentgenography usually does not help in differential diagnosis, since both types of pneumonias may present with a wide spectrum of x-ray as well as clinical findings.



Distinct mucoid colonies of type 3 pneumococci (*Streptococcus pneumoniae*) on sheep blood agar showing greenish discoloration (alpha-hemolysis) of medium. (b) Typical "fried-egg" colonies of *Mycoplasma pneumoniae* consisting of dense central core with hazy periphery. Cultural and serologic methods for detecting *pneumoniae* are complex, time-consuming, and not widely available.

Expectant therapy

A patient with a presumptive diagnosis of mycoplasmal pneumonia or bacterial pneumonia, it is desirable to initiate antibiotic therapy before culture and sensitivity results are available. A course of erythromycin or tetracycline is considered effective in the treatment of mycoplasmal pneumonia to help speed the clearing of infiltrate and shorten the duration of symptoms.^{1,3} In pneumococcal pneumonia, erythromycin is an effective alternative to penicillin, the drug of choice. A recent report, based on data from 200 hospitals of 100 beds or more, found that *S. pneumoniae* sensitive *in vitro* to erythromycin.⁴

Among these therapeutic agents, only erythromycin provides effective coverage of both *Mycoplasma pneumoniae* and *S. pneumoniae*. The penicillins are not effective against *Mycoplasma*, and *pneumoniae* has shown a relatively high incidence of resistance to tetracycline. When erythromycin is selected for therapy, E-Mycin (erythromycin enteric-coated tablets, Upjohn) is the drug of choice. E-Mycin is administered and absorbed as active erythromycin base, and may be given q.i.d., q 6h, or b.i.d., immediately after meals or between meals. Thus, patients can use mealtimes to help them remember their medication. The enteric coating on E-Mycin tablets helps ensure efficient absorption in the intestinal tract, and bioavailability studies show that E-Mycin can be expected to achieve predictable, acceptable blood levels. The cost of E-Mycin helps assure economical therapy. E-Mycin rarely causes serious side effects and is not associated with liver toxicity.* The most frequent side effects are upper gastrointestinal, such as abdominal cramping and discomfort, and are dose-related. Nausea, vomiting, and diarrhea occur infrequently with usual oral doses. Serious allergic reactions, including anaphylaxis, have rarely been reported.

*Mild to moderately severe, due to susceptible organisms

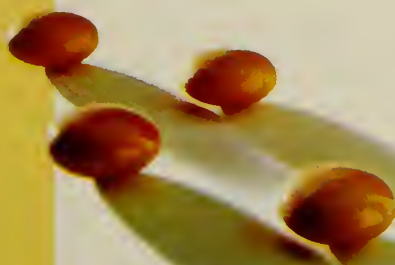
ICCS: 1. Chusid EL, Dalrymple W, Holloway WJ, et al: Managing the infectious diseases. *Patient Care* 9:122-167, 1975. 2. The occasional might of mycoplasma. *J Med* 7:82, 85, 1975. 3. Stevens DA: Viral and Mycoplasma pneumonias. *J Med* 55:81-86, 1974. 4. Data source: PMR Bacteriologic Report, Winter Series

Summary

Because pneumonias may be difficult to differentiate at the outset, treatment is often initiated before a causal diagnosis is made. However, readily available diagnostic criteria occasionally allow early differentiation between bacterial and nonbacterial pneumonias. When the diagnosis appears to be nonbacterial pneumonia, further differentiation between mycoplasmal pneumonia and viral pneumonia is more complex and time-consuming. Therefore, therapy is often initiated on the basis of a presumptive diagnosis of mycoplasmal pneumonia.

Erythromycin is an effective antibiotic against *Mycoplasma pneumoniae*, *Streptococcus pneumoniae*,[†] and *Streptococcus pyogenes*.[†] E-Mycin (erythromycin enteric-coated tablets, Upjohn) is administered and well absorbed as the active base, may be taken immediately after meals or between meals, and is essentially nontoxic.

[†]Although penicillin remains the drug of choice against these organisms, erythromycin is an effective alternative.



E-Mycin[®] 250 mg

erythromycin enteric-coated tablets, Upjohn

wide-ranging usefulness in pneumonia*

*Mild to moderately severe, due to susceptible organisms

Upjohn

The Upjohn Company, Kalamazoo, Michigan 49001, U.S.A.
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1975-1976 Data are a compilation of laboratory reports submitted during December 1975 and January and February 1976 by 200 acute care hospitals of 100 beds or more.

Please turn page for brief summary of prescribing information.

Wide-ranging usefulness in pneumonia*

E-Mycin® 250 mg
erythromycin enteric-coated
tablets, Upjohn

Upjohn

- For mild to moderately severe infections due to susceptible organisms that commonly invade the respiratory tract
- Essentially nontoxic (see Precautions and Adverse Reactions below)
- Documented bioavailability
- May be taken immediately after meals or between meals
- Active base formula produces predictable blood levels
- Formulated for quality...priced for economy

E-MYCIN® TABLETS — 250 mg — For Oral Administration (erythromycin enteric-coated tablets, Upjohn)

E-Mycin Tablets are specially coated to protect the contents from the inactivating effects of gastric acidity and to permit efficient absorption when administered either immediately after meals or when given between meals on an empty stomach.

Indications: *Streptococcus pyogenes* (group A beta-hemolytic streptococci): Upper and lower respiratory tract, skin, and soft-tissue infections of mild to moderate severity. Parenteral benzathine penicillin G is considered by the American Heart Association to be the drug of choice in the treatment and prevention of streptococcal pharyngitis and in long-term prophylaxis of rheumatic fever. When oral medication is necessary (because the parenteral route is contraindicated) or if there is known allergy to penicillin, the following recommendations made by the American Heart Association apply: 1) Oral penicillin G or V (where no allergy exists)—This is the drug of choice. Give for a minimum of 10 days; 2) Erythromycin—Give for a minimum of 10 days. A few strains of streptococci resistant to erythromycin have been reported.

Alpha-hemolytic streptococci (viridans group): Short-term prophylaxis against bacterial endocarditis prior to dental or other operative procedures in patients with a history of rheumatic fever or congenital heart disease who are hypersensitive to penicillin. (Erythromycin is not suitable prior to genitourinary surgery where the organisms likely to lead to bacteremia are gram-negative bacilli or the enterococcus group of streptococci.) *Staphylococcus aureus*: Acute infections of skin and soft tissue of mild to moderate severity. Resistance may develop during treatment.

Diplococcus pneumoniae: Upper respiratory tract infections (eg, otitis media, pharyngitis) and lower respiratory tract infections (eg, pneumonia) of mild to moderate degree.

Mycoplasma pneumoniae (Eaton agent, PPLO): In the treatment of primary atypical pneumonia, when due to this organism.

Treponema pallidum: Infections due to this organism.

Corynebacterium diphtheriae and *Corynebacterium minutissimum*: As an adjunct to antitoxin, to prevent establishment of

carriers, and to eradicate the organism in carriers. In the treatment of erythrasma.

Entamoeba histolytica: In the treatment of intestinal amebiasis only. Extraenteric amebiasis requires treatment with other agents. *Listeria monocytogenes*: Infections due to this organism.

Contraindication: Contraindicated in patients with known hypersensitivity to erythromycin.

Warning: Safety for use in pregnancy has not been established.

Precautions: Erythromycin is principally excreted by the liver. Caution should be exercised in administering the antibiotic to patients with impaired hepatic function. Surgical procedures should be performed when indicated.

Adverse reactions: The most frequent side effects of erythromycin preparations are gastrointestinal, such as abdominal cramping and discomfort, and are dose-related. Nausea, vomiting, and diarrhea occur infrequently with usual oral doses. During prolonged or repeated therapy, there is a possibility of overgrowth of nonsusceptible bacteria or fungi. If such infections occur, the drug should be discontinued and appropriate therapy instituted. Mild allergic reactions such as urticaria and other skin rashes have occurred. Serious allergic reactions, including anaphylaxis, have been reported.

Treatment of overdose: The drug is virtually nontoxic, though some individuals may exhibit gastric intolerance to even therapeutic amounts. Allergic reactions associated with acute overdose should be handled in the usual manner—that is, by the administration of adrenalin, corticosteroids, and antihistamines as indicated and the prompt elimination of unabsorbed drug, in addition to all needed supportive measures.

How supplied: 250 mg enteric-coated tablets—in bottles of 100 and 500 tablets, and in unit-dose packages of 100 tablets. Caution: Federal law prohibits dispensing without prescription.

For additional product information, consult the package insert or see your Upjohn Representative.

NAS-4

The Upjohn Company, Kalamazoo, Michigan 49001, U.S.A.
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*Mild to moderately severe, due to susceptible organisms.

If your angina patient* isn't having 3 out of 4 better days than usual... try Cardilate® (ERYTHRITYL TETRANITRATE)

*Please note: unstable angina patients may be refractory to all long-acting nitrates.

INDICATIONS For the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset of action is somewhat slower than that of nitroglycerin.

PRECAUTIONS As with other effective nitrates, some fall in blood pressure may occur with large doses.

Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilatation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

SIDE EFFECTS No serious side effects have been reported. In sublingual therapy a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrites, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustment of the cerebral hemodynamics to the initial marked cerebral vasodilatation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

SUPPLIED 10 mg chewable tablets, bottle of 100. Also 5, 10 and 15 mg scored tablets in bottles of 100. 10 mg scored tablets also supplied in bottle of 1,000.

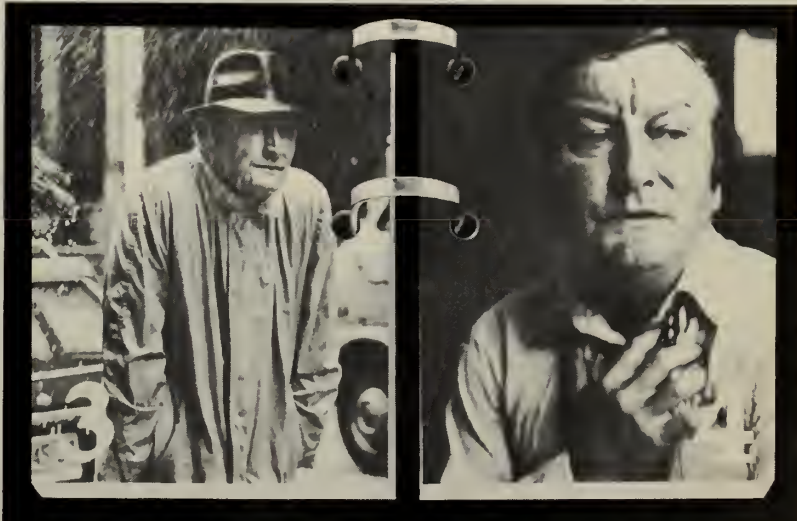
Also available: Cardilate® P brand Erythryl Tetranitrate with Phenobarbital* (*Warning: may be habit-forming).

1. Russek HJ. AM J M Sc 239:478, 1960



"Pain days" significantly reduced with Cardilate® (erythryl tetranitrate) in 48-patient study.¹ Patients on placebo experienced same pain as usual or increased pain 2 days out of 3... compared to 1 day out of 4 while on Cardilate.

Rapid-acting chewable tablets (10mg) preferred by many patients. Should be given before anticipated periods of stress to produce an action within 5 minutes and lasting up to 2 hours. Sublingual tablets also available.

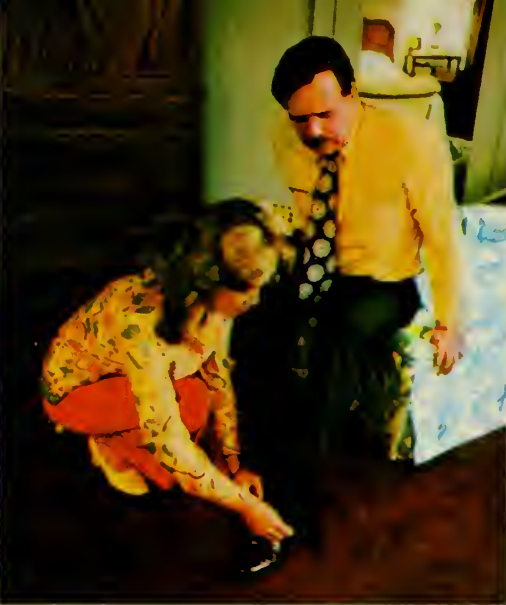


Effective prophylaxis against attacks; increases exercise tolerance. Serious side effects have not been reported in 20 years' clinical use.

Cardilate can save patients money; is less expensive than many popular long-acting nitrates. 20% to 30% savings not uncommon...also helps reduce need for nitroglycerin.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709





WALLACE LABORATORIES
Division of Carter-Wallace, Inc.
Cranbury, New Jersey 08512

The promise of Soma in the "low-back" patient: relief of discomfort... improved function

In 3 double-blind, randomized, placebo-controlled studies¹⁻³ of patients with acute, painful musculoskeletal disorders affecting the back, Soma helped effect...

- significant relief of discomfort, stiffness and other symptoms
- significant improvement in range of motion as measured by objective tests of function.

Add Soma to your standard regimen for low-back disorders...and, if necessary, add your choice of analgesic. Then let your patient report the results.

In acute, painful low-back disorders

Soma[®] 350 (carisoprodol) 350 mg tablets for measurable relief

Indications: Carisoprodol is indicated as an adjunct to rest, physical therapy, and other measures for the relief of discomfort associated with acute, painful musculoskeletal conditions.

Contraindications: Acute intermittent porphyria and allergic or idiosyncratic reactions to carisoprodol or related compounds such as meprobamate, mebutamate, tybamate.

Warnings: *Idiosyncratic Reactions:* Rarely, extreme weakness, transient quadriplegia, dizziness, ataxia, temporary vision loss, diplopia, mydriasis, dysarthria, agitation, euphoria, confusion and disorientation have appeared within minutes or hours of the first dose.

These usually subside in several hours but supportive and symptomatic therapy, including hospitalization, may be necessary.

Pregnancy and Lactation: Safe use not established; weigh potential benefits against potential hazards in pregnancy, nursing mothers (concentrations in breast milk are two to four times that in plasma), or women of childbearing potential.

Children Under Twelve: Not recommended.

Potentially Hazardous Tasks: Driving a motor vehicle or operating machinery.

Additive Effects: Effects of carisoprodol and alcohol, other CNS depressants or psychotropic drugs may be additive.

Drug Dependence: Use cautiously in addiction-prone patients.

Precautions: To avoid excess accumulation, use caution in patients with compromised liver or kidney function.

Adverse Reactions: *Central Nervous System:* Drowsiness, dizziness, vertigo, ataxia, tremor, agitation, irritability, headache, depressive reactions, syncope, insomnia, idiosyncratic reaction (see "Warnings").

Allergic or Idiosyncratic: In previously unexposed patients, these are usually seen after 1-4 doses and include rash, erythema multiforme, pruritus, eosinophilia, fixed drug eruption with cross reaction to meprobamate. Asthmatic episodes, fever, weakness, dizziness, angioneurotic edema, smarting eyes, hypotension and anaphylactoid shock may be manifestations of severe reactions.

In such cases, stop carisoprodol and initiate appropriate treatment (e.g., epinephrine, antihistamines, corticosteroids).

Cardiovascular: Tachycardia, postural hypotension, facial flushing.

Gastrointestinal: Nausea, vomiting, hiccup, epigastric distress.

Hematologic: Leukopenia and pancytopenia (an carisoprodol plus other drugs).

Usual Adult Dosage: One 350 mg tablet three times daily and at bedtime.

Overdosage: Has produced stupor, coma, shock, respiratory depression, and, very rarely, death. The effects of an overdosage of carisoprodol and alcohol or other CNS depressants or psychotropic agents can be additive even when one of the drugs has been taken in the usual recommended dosage. Empty stomach, treat symptomatically; cautiously give respiratory assistance, CNS stimulants, pressor agents as needed. Carisoprodol is metabolized in the liver and excreted by the kidney. Diuresis and dialysis have been used successfully with related drug meprobamate. Carefully monitor urinary output; avoid overhydration; observe for possible relapse due to incomplete gastric emptying and delayed absorption.

Before prescribing, consult package circular or latest PDR information.

1. Hindle, T.H. III: Calif. Med., 117:7 (Aug.) 1972. 2,3. Unpublished Data on file, Medical Department, Wallace Laboratories, Cranbury, N.J.

Pennsylvania's Dr. Blumberg wins Nobel Prize

Baruch S. Blumberg, M.D., associate director for clinical research at the Institute for Cancer Research, Fox Chase, has been awarded the 1976 Nobel Prize for Medicine for his research involving the hepatitis B virus, its detection, elimination, and connection with liver cancer.

He shares the award with D. Carleton Gajdusek, M.D., of the National Institute for Neurological Diseases, Bethesda, Maryland, who has been researching a virus causing mental disorders in the Fore Indians of New Guinea.

In 1963 Dr. Blumberg discovered the "Australia antigen" in the blood of Australian aborigines, which helped him to develop a test to detect the pres-



DR. BLUMBERG

ence of the hepatitis B virus in the blood.

More recently he and his asso-

ciates have developed a hepatitis vaccine, which is currently being field tested, and have been studying the link between hepatitis B virus and cancer of the liver.

Dr. Blumberg received his medical degree from Columbia University and began work in a hospital in Surinam on the northeastern coast of South America. During his stay in Surinam he began the research which led to the discovery of the Australia antigen.

In addition to their work with the hepatitis B virus, Dr. Blumberg and his associates are currently involved in the study of other antigens which they have recently identified.

Blue Shield requests rate increase; Dr. Bachman calls for consumer control

Hearings were held October 8 on the request of Pennsylvania Blue Shield for a rate increase which will average approximately 25 percent and affect all community rated group and nongroup subscribers.

The Blue Shield Board of Directors in August approved authorization of the rate request because of underwriting losses since 1970. As of June 30 Blue Shield reserves were less than \$2.8 million, or under 0.75 percent of annual income. Reserves of 10 percent of annual income are considered to be a critical level.

At the hearing Robert E. Rinehimer, PBS president, said that Blue Shield has experienced

a 30 percent increase in the use of benefits by subscribers in the past two years, but that the number of subscribers has increased only 3 percent in the same period. He attributed this in part to the malpractice crisis which has caused "tremendous increases in malpractice insurance premiums" as well as the practice of defensive medicine.

Rinehimer cited four additional reasons why Blue Shield lost \$45 million from its reserve fund in the past four years. They are: 1. Inflation; 2. The addition of new benefits without premium increases, costing through 1975 \$87 million; 3. Sixty-five special losses, with a cumulative loss through 1976 of \$17 million; and

4. Rejection of or granting of less than half of rate increase requests in 1971-72 and 73.

Secretary of Health Leonard Bachman, M.D., testified at the hearing and announced that for the first time in history the Department of Health, at his direction, will assert its regulatory authority over Blue Shield, a role it shares under law with the Insurance Department.

He said he would appoint a task force composed of consumers and providers to assist the department "to better perform its statutory responsibilities as a regulator of Blue Shield so as to maintain a high level of care and yet contain costs."

He asked for the support of the Insurance Department in recommending to the General Assembly legislation mandating that a majority of the Blue Shield Board of Directors be consumers.

AMA Clinical Convention features 65 topics

A new feature will be included in the program of the 30th annual Clinical Convention of the American Medical Association, December 4-7, in Philadelphia.

According to R. Robert Tyson, M.D., program chairman, and professor and chairman of the department of surgery at Temple University School of Medicine, five selected scientific exhibits will be enhanced by limited-attendance seminars. Each seminar will be conducted by a prominent physician in the field who will discuss and expand on the information given in the exhibit.

Exhibits to be discussed in seminars are in the areas of coronary artery disease, extracranial cerebral vascular disease, artificial joints, arthritis, and physical examination.

A total of 65 topics will comprise the scientific sessions of the Clinical Convention. Expected to be among the highlights are ses-

sions on: electrocardiographs, by William S. Frankl, M.D., professor



DR. TYSON

of medicine and director of the division of cardiology for the Medical College of Pennsylvania; current controversies in management of breast cancer, by

George Rosemond, M.D., immediate past president of the American Cancer Society and a past president of the State Society; and nutrition, by Jonathan Rhoads, M.D., professor of surgery at the University of Pennsylvania and recipient of the State Society's Distinguished Service Award for 1976.

All scientific meetings are scheduled to be held in the Philadelphia Convention Center, except luncheon meetings which will take place at the Hilton Hotel.

Dr. Jones at Blue Shield

David J. Jones, M.D., of York, has been named vice president-utilization for Pennsylvania Blue Shield. He succeeds Edward R. Thoms who has been named vice president-claims administration.

Dr. Jones most recently has served as director of patient care review, associate director of medical education, and coordinator of community medicine at York Hospital. He is a consultant to the Pennsylvania Medical Care Foundation and associate professor of medicine at the University of Maryland School of Medicine.

A native of Elwood City, Dr. Jones earned his undergraduate degree at Grove City College and his degree in medicine at Jefferson Medical College of Thomas Jefferson University. At the University of Pittsburgh he received the degree of Master of Public Health in Medical Care Administration. Before coming to York, Dr. Jones was director of the program evaluation center at the University of Missouri School of Medicine. He is a member of the State Society, the AMA, and the American College of Preventive Medicine, and is a diplomate of the American Board of Preventive Medicine.



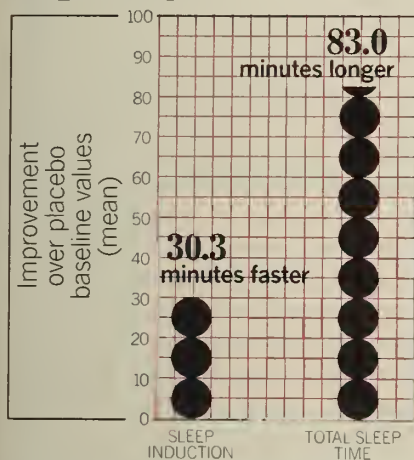
ANNUAL SESSION ISSUES were the subject of a Ninth Councilor District meeting in Oil City prior to the meeting in Philadelphia. Carol N. Maurer, M.D., trustee, is shown above at the rostrum. James Paxton of the State Society staff is shown on the left. John F. Rineman, executive vice president, and Dale E. Yates, of the staff, on the right, also spoke at the meeting.

The ultimate objective test: sleep laboratory proof of effectiveness... now in geriatric insomnia patients

Six female insomniacs, ranging in age from 67 to 82 years, received Dalmane (flurazepam HCl) for seven consecutive nights in the sleep research laboratory.¹ Improvement over pre-treatment baseline levels was significant for sleep induction and sleep maintenance ($p < .05$). And the greater the sleep problem in these patients, the better the effect with Dalmane (significant correlation at $p < .01$ level).



Elderly insomniacs fell asleep faster, slept longer¹



Results expand and confirm objective proof of efficacy in younger adults with insomnia

The effectiveness of Dalmane (flurazepam HCl) was demonstrated in earlier studies of 32 younger adults with trouble falling asleep, staying asleep or sleeping long enough.² On average, in these studies, Dalmane induced sleep within 17 minutes and provided 7 to 8 hours of sleep, at the same time reducing number of nighttime awakenings.

Relative safety, even in patients on warfarin

Morning "hang-over" has been relatively infrequent with Dalmane. And no unacceptable fluctuation in prothrombin time has been reported in warfarin patients on Dalmane.^{2,3} The usual adult dosage is 30 mg *h.s.*; in elderly and debilitated patients, limit initial dosage to 15 mg to help preclude oversedation, dizziness or ataxia.

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and

falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

REFERENCES:

1. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
3. Robinson DS, Amidon EL: Interaction of benzodiazepines with warfarin in man, in *The Benzodiazepines*, edited by Garattini S, Mussini E, Randall LO. New York, Raven Press, 1973, p. 641

New evidence proves insomnia relief in elderly patients

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Government prepares for medicaid abuse crackdown

The Pennsylvania Department of Public Welfare is expanding and intensifying efforts to discover all cases of fraud and abuse through a new special investigation unit, Frank S. Beal, department secretary, has announced.

Practices receiving attention are: overutilization and abuse by "medicaid mills" in certain areas; rebates from laboratories to physicians, pharmacists, and other medical providers; fraudulent and duplicate billing; and fraudulent billing by laboratories for tests not ordered by a physician, or billing for a number of individual tests when results were obtained in one test procedure.

Beal said: "The new unit is concentrating on cases of flagrant fraud. We do not intend to prosecute clients or providers who may have received overpayment through employee error or misunderstanding of the regulations. All cases which are found to

involve violation of the law will be prosecuted."

During the first six months of 1976 DPW collected more than \$184,000 in restitution from 63 medical providers, and expects to collect an additional \$195,000 as a result of action initiated during that period.

The department's activity reflects the concern expressed by the Medical Services Administration (MSA) which administers the \$16.5 billion a year medicaid program at the federal level. An arm of the Social and Rehabilitation Service of the Department of Health, Education, and Welfare, MSA has announced several new appointments to top positions. Those appointed will be responsible for improving the effectiveness of the medicaid program and assuring that the states fulfill the medicaid statutory requirements for controlling the use of health care services.

Medicaid costs increase by about \$2.5 billion annually, ac-

cording to Robert Fulton, new administrator of Social and Rehabilitation Services, who spoke in Harrisburg recently at a meeting of the National Welfare Fraud Association. For that amount of increase, he said, the same number of people (23 million) receive the same level of treatment as previously. He said fraud on the part of recipients and providers is believed to account for from 10 to 15 percent of the money spent in the program. Fulton said HEW is encouraging states to weed out persons who are misusing the program, and in 1977 will investigate the 10 to 12 states with the highest medicaid budgets—including Pennsylvania—to determine how the program is handled.

HUP has new director

Thomas S. Powell has been appointed executive director of the Hospital Utilization Project, Pittsburgh.

Powell is former director of professional affairs for the Hospital Association of Pennsylvania. He has served professionally on committees and councils in state government and health related organizations. He has been named an honorary member of the American College of Utilization Review Physicians and holds memberships in the American Academy of Medical Administrators, American Hospital Association, National League and Pennsylvania League for Nursing, and the Pennsylvania Association of Utilization Review Coordinators. Paul M. Lewis, M.D., former HUP director, has been named regional medical director of the Department of Health's northwest district office in Meadville.



THE MONTGOMERY COUNTY Medical Society and the Montgomery County Bar Association held their thirteenth annual medical-legal dinner recently at the Whitmarsh Valley Country Club. Shown at the event are, left to right: Alan L. Dorian, M.D., president of the Montgomery County Medical Society; William J. Kelly, M.D., State Society president; Albert E. Jenner, Jr., Esq., guest speaker; A. Benjamin Scirica, presiding judge of Montgomery County courts; and Joseph M. McGrory, Esq., president of the Montgomery County Bar Association.

Dr. Pressman testifies on fifth pathway for State Society

Robert S. Pressman, M.D., Philadelphia internist and member of the Society's Commission on Accreditation, presented the Society's position on the Fifth Pathway provision in H.B. 1976 at Senate Education Committee hearings October 13, at the Bellevue-Stratford Hotel, Philadelphia.

Dr. Pressman stated that the State Society strongly supports the Fifth Pathway program as proposed in House Bill 1976 because of the number of benefits for the state as well as the student.

"Access to better training programs is the most immediate and most valuable benefit for the student," said Dr. Pressman. "The program gives that person an additional year to make a career choice in medicine. . . . It gives the student a chance to become accustomed to the social and cultural features of the American teaching hospital, before beginning one of the most important parts of the training for the practice of medicine in the United States: internship and residency now termed graduate training. . . .

"These students represent a group of sons and daughters of ambitious, productive, active people of Pennsylvania, who have been caught up in the pre-medical population explosion. They have had four to six years of education abroad, often have lived in less than pleasant surroundings in the foreign country, at great financial expense to their families. . . . The efforts and energies of these citizens of our State are both rewarded and recognized in the Fifth Pathway program.

Another benefit to the State pointed out by Dr. Pressman is cost effectiveness. "Plainly put, someone else has paid for the

first four years of medical education. We pick up one fifth of the cost and in the process we pos-



DR. PRESSMAN

sess additional physician manpower for the benefit of Pennsylvania. . . . with more available

physician manpower, the cost of medical service can come down.

"With at least three qualified applicants for every medical school space today, there continues to be a great need for adequate means for training physicians. Any program that encourages and expedites this training process should be heartily supported."

In addition to his work on the Commission on Education and Manpower, Dr. Pressman served for six years as chairman of the State Society's Interspecialty Committee. Through his work with the subcommittee on residents and interns, he gained considerable knowledge about the problems of American students coming out of foreign medical schools.

Dr. Collins education head

James A. Collins, Jr., M.D., has been elected president of the Institute for Medical Education and Research at the Geisinger Medical Center in Danville.

He succeeds Robert Dickey, M.D., who had been president since 1974, a member of the board of directors since 1962, and on the medical staff for 28 years.

Robert Folk, M.D., vice president for medical education at Geisinger, was elected vice president and a member of the board of directors. Other officers are: Robert J. Keating, Scranton, secretary treasurer and member of the board; Joseph Kreder, Clarks Summit, member of the board; and Howard P. Hare, assistant secretary treasurer.

Dr. Collins joined the Geisinger medical staff in 1943. He was appointed director of the department of internal medicine in 1958

and chairman of the division of medical services in 1974. Prior to his election as president of the institute, he had served on its Board of Directors and administrative council. He is former chairman of the State Society's Council on Education and Science.

Recently Dr. Collins was elected chairman of the AMA Joint Review Committee for Educational Programs for Physicians' Assistants. He is a director of the National Commission on Certification of Physician's Assistants and a trustee of the American Society of Internal Medicine.

Allergists elect officers

The Philadelphia Allergy Society elected new officers during a recent reorganizational meeting.

The officers are: Samuel S. Burden, M.D., president; Charles G. Blumstein, M.D., vice president; and Patricia A. Nell, M.D., secretary treasurer.

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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



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* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioğlu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25

(methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandro-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunichism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome." *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Managing professional liability risks—everyone's job

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Most of us have had some exposure to the management of an insurance risk. We have had visits from such organizations as the Association of Fire and Casualty Underwriters to check the premises of our homes and businesses; there have been physical examinations and insurance company analyses of our business lives for partners insurance and professional corporation insurance. All are designed to better control and otherwise define the risk. In some instances, these risk management efforts have a distinct payoff through

lower premiums or at least stability in access to the insurance market. But we may have failed (or we may not have tried) to solve similar problems in professional

Mr. Archer has written on previous occasions for PENNSYLVANIA MEDICINE. This article was prepared at the request of the editors in a continuing effort to fulfill a request of the Society's Board of Trustees that information on malpractice loss prevention be provided to the membership.

liability insurance. If the practice of medicine were primarily a scientific endeavor, the assessment of risk would be somewhat more of an arithmetic problem. But we are dealing with people, tradition, philosophy, and particularly art, all of which are generally not quantifiable in arithmetic terms. Take, for example, a recent study done on the classification of health problems. Here, four faculty physicians who gave care to patients in a family medicine center made diagnoses of patients' conditions in many cases significantly different from the

peer conclusion. A summary of that experience is reproduced at the end of this article. Assuming the integrity of this study, the conclusions argue the notion that the practice of medicine is less a science and more an art, thereby raising a host of nonquantifiable risk management questions.

On the scientific side, a recent report from the National Academy of Sciences on post-surgical death rates stated there "... is a differential performance depending upon the type of patient (operation) so that hospitals may do better than average for one operation and worse than average for another." What makes the difference? "The organizational and other characteristics of hospitals show significant variation, and this ... may account for substantial portions of the differences. ..." The report also notes "... it may be that a staff characterized as having more experienced (and therefore older) members is less progressive or less willing to exert tight controls over its members and therefore has poorer outcomes. ... Where the qualifications were measured by years of experience, most especially for surgeons, the outcomes were not improved by higher qualifications, independent of role complexity."

This study on the science of medicine, while not conclusive by itself, has an important concept in common with the former study on the art of medicine; there are at least quantifiable measures available such as experience, age, and tight controls which may be predictive of risk management outcomes. **Hence, if a house is well ordered and those reasonable controls which affect outcome have been applied, then there may be a material effect on the bottom line, which at the moment is increasing incidence and greater awards resulting from professional negligence.**

The following analogy may bring the matter in better focus. The airline captain represents the culmination of a complex, lengthy, and rigidly structured educational and experience process. Most captains have progressed from student solo capability at 10 flying hours to a private license at 40 hours to a commercial pilot license which permits working for hire at 250 hours and requires an instrument rating for bad weather flying, and finally to eligibility for captain status at 1500 flying hours, which is the top of the line.* To reach that point, each step along the way was conditioned by comprehensive written and intensive flying examinations, plus study and check rides each time another type aircraft or class was flown. In fact, for the captain there is a mandatory check ride required every six months to be done by either the Federal Aviation Administration or a company examiner. In addition to experience and demonstrated proficiency requirements, the aspiring pilot must submit to regular comprehensive physical examinations by designated examiners which increase in frequency, complexity, and precision from once every two years through private pilot to once a year for the commercial pilot to once every six months for the airline captain. Most pilots dread these physical exams because it can spell the end of their careers.

In addition to the foregoing experience and physical requirements, there are a host of regulations which determine the conditions under which the captain must function. Some examples include: the pilot may not imbibe alcoholic beverages later than eight hours prior to a flight; there

is the obligation to report equipment malfunctions and fellow pilot performance which may jeopardize safety; there are a specified minimum number of instrument landings to be done within a specified time; and the airlines mandate retirement at age 60. The regulatory list for pilots is almost endless, but it is all done with one goal in mind—to protect the public interest.

The correlations between the pilot's responsibility and the physician's responsibility are obvious. The difference between the two is basically one of institutionalization. The rules governing pilots are fixed by administrative law; the rules governing physicians are fixed by peers. **What are the rules fixed by physician peers? Are they good enough? Were an administrative law regulator to look at the practice of medicine in hospitals, for example, the rules might go something like this:**

Education

"Each physician practicing within the hospital must meet minimum and continuing education requirements." (There would follow a detailing of what those requirements are for each specialty, such as board certification and continuing education).

Experience

"Each physician practicing in the hospital must meet minimum experience requirements." (There would follow separate requirements for surgeons, generalists, and so forth. This particular section would include minimum frequency of specified operative procedures, demonstrated proficiency through periodic observations by peers and normal tissue limits plus outcomes evaluation. Hospital-based physicians would be judged on

**As a practical matter, most jet airline captains have no less than 10,000 hours of flight time.*

outputs through independent evaluations. Medical practitioners would be evaluated in terms of diagnostic capabilities and treatment outcomes).

Physical and Mental Capacity

"Each physician practicing in a hospital must periodically be evaluated for physical and mental capability." (There would follow in this section a summary of those physical and mental capabilities, including age minimums, which correlate with the physician's privilege, such as manual dexterity for surgeons, eyesight for radiologists, emotional stability for internists, and so forth).

There would also be rules for hospitals to follow; just as aircraft are under maintenance schedules and regulations, so too would hospital equipment be under maintenance and regulation. The recent faulty x-ray

equipment disaster would probably not have occurred had such rules been rigid and subject to scrutiny by a third party.

No one likes to follow rules and regulations which tend to control all aspects of one's endeavor. Pilots say, "it takes all the fun out of it." But in the final analysis, they do use the system and are grateful for it. The problem confronting pilots is the bureaucratic extreme wherein the rulemakers (policymakers) have a tendency to pursue their own philosophical objectives which change from time to time as the guard changes. Thus, if we go to rulemaking, we must be certain of checks and balances. But between now and that day (if it ever comes and it needn't come), the providers should get together and make the rules on a voluntary basis. If that's done, the professional liability problem will

present itself as a historical oddity.

It is the opinion of the Pennsylvania State Insurance Department that insurance companies, as well as physicians, hospitals, and other providers, have risk management responsibility. It is the department's intention to require of insurance companies providing professional liability insurance in the Commonwealth ongoing cooperative risk management programs as a condition of doing business.

Also, since Act 111, the Health Care Services Malpractice Act of 1975, has been amended to permit self-insurance, similar requirements will be placed on those seeking this exception. Clearly, if we are to stop negligence, we must address the matter forthrightly and it must be done by the profession. The alternative is regulation. □

Diagnostic Frequency of Faculty Members by ICHPPC Section
in Per Cent of Total Diagnoses*

ICHPPC SECTION	A	B	C	D	All
1. Infective	2.1	4.6	6.0	4.8	4.7
2. Neoplasm	1.4	1.4	0.9	0.7	0.8
3. Endocrine	5.8	7.6	4.1	3.0	5.7
4. Blood	0.2	0.9	0.4	0.9	0.5
5. Mental	9.5	8.3	6.0	4.2	7.2
6. Nervous	4.9	6.9	3.9	4.5	4.8
7. Circulatory	7.8	8.5	11.0	8.8	9.0
8. Respiratory	6.3	11.3	7.8	9.7	8.2
9. Digestive	3.5	1.9	4.0	4.2	3.5
10. Genitourinary	4.3	5.5	4.6	6.1	4.8
11. Pregnancy	0.2	0.1	0.1	0.1	0.1
12. Skin	5.7	4.7	5.5	3.5	5.2
13. Musculoskeletal	4.0	2.3	3.6	5.0	4.1
14. Congenital	0.6	0.1	0.1	0.1	0.1
15. Perinatal	0.1	0.1	0.1	0.1	0.1
16. Symptoms	11.9	10.7	5.6	8.2	7.8
17. Accident	4.1	3.2	9.4	8.6	6.2
18. Supplemental	20.9	15.6	22.1	20.7	21.4

Diagnostic rates adjusted for age and sex of the patient population of each physician.

* From, Jack, M.D., "The International Classification of Health Problems for Primary Care," *Medical Care*, May, 1976, pp. 450-454.

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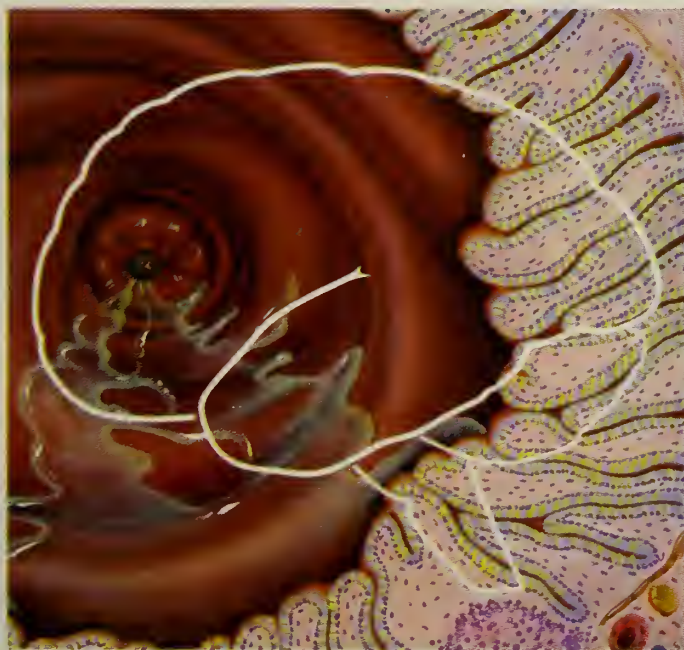
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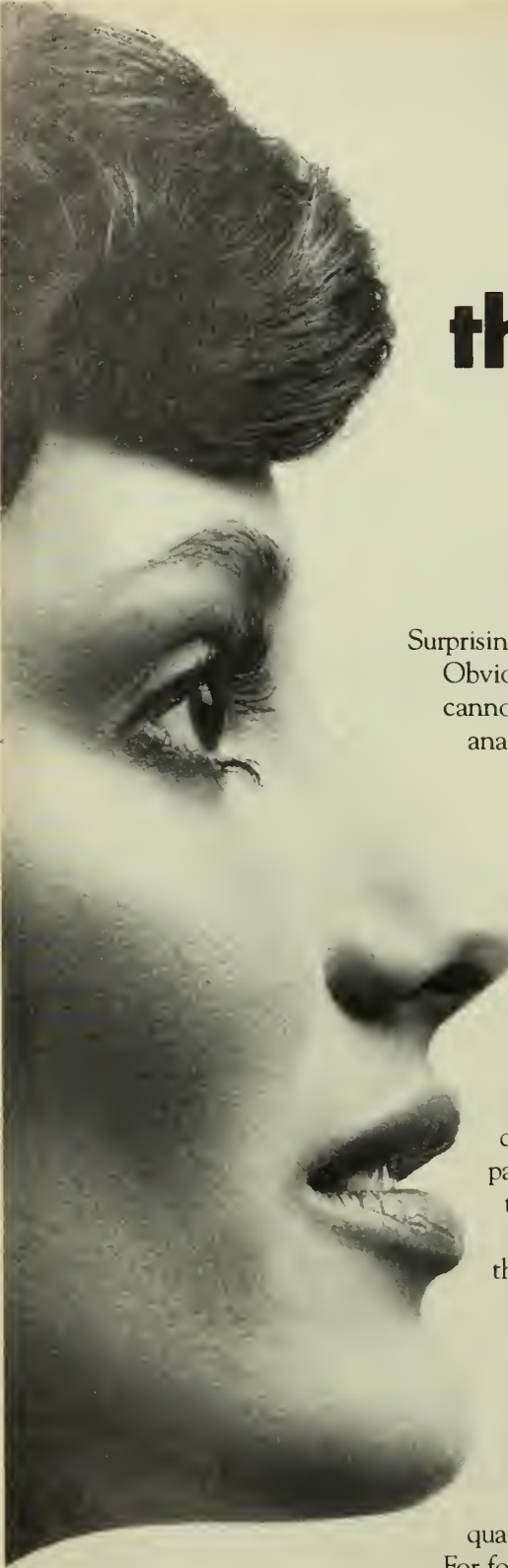
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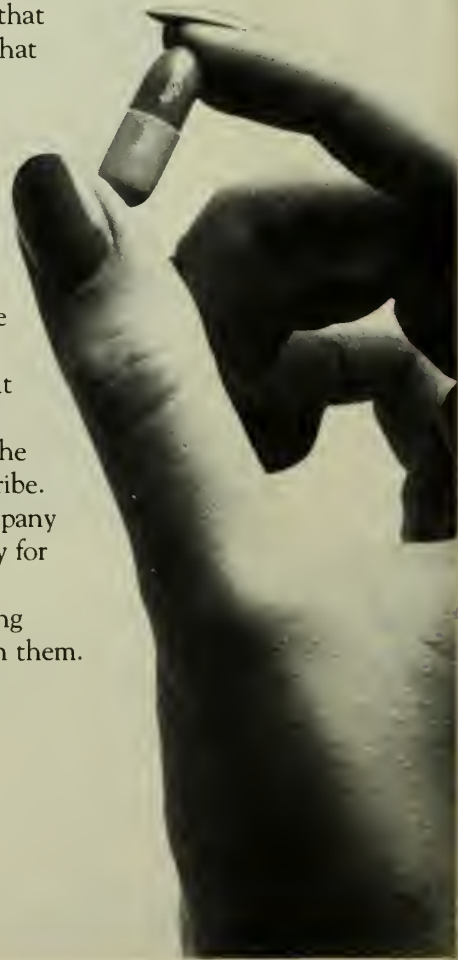
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Camera views 1976 House of Delegates



JOHN B. LOVETTE, M.D. was elected the Society's new vice president, but is shown above fulfilling his duties as speaker of the 1976 House of Delegates. Full election results appear on page 30, the proceedings of the House of Delegates on page 66, and the convention addresses of President William J. Kelly, M.D., and Past President David S. Masland, M.D., on pages 59 and 62 respectively.



John V. Blady, M.D., received the badge of president elect from George A. Rowland, M.D., chairman of the Board, at the State Dinner.



TINY Columbia County Medical Society is home territory for two top officers of the State Society—D. Ernest Witt, M.D., was elected speaker of the House, and George A. Rowland, M.D., was re-elected chairman of the Board.



THE DISTINGUISHED SERVICE AWARD was presented by President William J. Kelly, M.D., to John P. Hubbard, M.D., of Philadelphia.



THE 1976 HOUSE OF DELEGATES



House of Delegates names 1976-77 officers

As William J. Kelly, M.D., Pittsburgh; John V. Blady, M.D., Philadelphia; and John B. Lovette, M.D., Johnstown, moved into the offices of president, president elect, and vice president, a number of Society posts were filled at the 1976 Annual Meeting of the House of Delegates.

D. Ernest Witt, M.D., of Bloomsburg, was elected speaker of the House of Delegates; and Donald E. Harrop, M.D., of Phoenixville, was elected vice speaker. G. Winfield Yarnall, M.D., of Harrisburg, was elected Society secretary.

At the Board's reorganization meeting following the final session of the House, George A. Rowland, M.D., of Columbia; and William C. Ryan, M.D., of Somerset, were elected chairman and vice chairman respectively.

The following appointments were made by the Board of Trustees: David A. Smith, M.D., Harrisburg, as medical editor of **PENNSYLVANIA MEDICINE**; Pepper, Hamilton, and Scheetz as legal counsel; and Executive Vice President John F. Rineman as treasurer of the Society.

The following committee appointments were made: Executive Committee—Dr. Rowland, chairman; Dr. Blady; Leroy A. Gehris, M.D.; Dr. Kelly; Dr. Lovette; David S. Masland, M.D.; and Dr. Ryan.

Finance Committee—Dr. Gehris, chairman; Donald R. Cooper, M.D.; Kenneth L. Cooper, M.D.; Raymond C. Grandon, M.D.; and David J. Keck, M.D.

Publication Committee—Dr. Keck, chairman; David W. Clare,

M.D.; Dr. Donald Cooper; Orlo G. McCoy, M.D.; and Joseph M. Stowell, M.D.

The Board of Trustees has a new ad hoc committee in addition to those already functioning on malpractice insurance, physicians' unions, and proposed regulations to the Medical Practice Act. The new ad hoc committee to study committees and commissions has the following members: Dr. Ryan, chairman; Dr. Kenneth Cooper; Dr. Grandon; and Dr. Kelly.

Delegates also elected district censors including: James H. Allison, M.D., of Gettysburg; William D. Stewart, M.D., of Allison Park; John G. Hallisey, M.D., of Aliquippa; Philip C. Grana, M.D., of Bedford; Brian A. Wummer, M.D., of Womelsdorf;

Arthur B. King, M.D., of Sayre; Stanley F. Peters, M.D., of Plumsteadville; Robert C. McCorry, M.D., of Butler; Warren F. White, M.D., of Johnstown; H. Richard Ishler, M.D., of State College;

Grant W. Bamberger, M.D., of Honey Brook; Theodore R. Koenig, M.D., of Knox; George J. Treires, M.D., of Lock Haven; John W. Hurst, M.D., of Altoona; David D. Kirkpatrick, Jr., M.D., of Meadville;

Hans S. Roe, M.D., of Carlisle; Robert P. Dutlinger, M.D., of Harrisburg; Richard W. Garlichs, M.D., of Havertown; Robert J. Dickinson, M.D., of Ridgway; Robert L. Loeb, M.D., of Erie; Veronica Binns, M.D., of Brownsville;

Albert W. Freeman, M.D., of

Shippensburg; David L. Avner, M.D., of Greensboro; Ralph F. Waldo, M.D., of Indiana; Nicholas F. Lorenzo, M.D., of Brockway; Norman S. Berger, M.D., of Scranton; William G. Phippen, M.D., of Lancaster;

C. Ray Bell, M.D., of Lebanon; Frederick A. Dry, M.D., of Emmaus; Samuel T. Buckman, M.D., of Wilkes-Barre; Franklin G. Wade, M.D., of Williamsport; Bruno P. Sicher, M.D., of Kane; Anderson W. Donan, M.D., of Grove City;

Donald E. Basom, M.D., of McAlisterville; Claus G. Jordon, M.D., of E. Stroudsburg; Rudolph K. Glocker, M.D., of Royersford; William O. Curry, M.D., of Danville; Walter J. Filipek, M.D., of Hellertown; J. Mostyn Davis, M.D., of Shamokin;

James O. Rumbaugh, Jr., M.D., of Newport; Charles M. Thompson, M.D., of Philadelphia; Francisco B. Villa, M.D., of Coudersport; Gabriel M. Lizak, M.D., of Pottsville; Alexander Solosko, M.D., of Meyersdale; Michael Markarian, M.D., of Hallstead;

William A. Coolidge, M.D., of Wellsboro; Joseph Weightman, M.D., of Lewisburg; Kenneth H. Heasley, M.D., of Tionesta; Donald J. Furman, M.D., of Warren; John C. McGinnis, M.D., of Washington; Howard R. Patton, M.D., of Honesdale;

Leslie S. Pierce, M.D., of Greensburg; John S. Rinehimer, Jr., M.D., of Tunkhannock; Donald R. Gross, M.D., of York; Gerald H. Weiner, M.D., of New Castle; Fred Pease, M.D., of Clearfield; and Donald W. Minter, M.D., of Worthington.



Can we legislate good health?

The term "practice of preventive medicine" connotes the promotion of behavior that implies on the basis of probable evidence a state of health. Health is defined as physical and mental wellbeing. Modern day emphasis on health maintenance and the nature of diseases which now represent the highest statistical death rates have presented a rigorous challenge to the medical profession.

At one time public health and preventive medicine meant primarily inoculation and pest control. The medical profession became adept in the care and cure of infectious disease, and with the sharp reduction in these illnesses, the chronic diseases—stroke, cancer, and heart disease—have become the leading causes of death. A number of supposedly causative factors have been cited, among which are a broad spectrum of environmental and behavioral elements. Poor nutrition, poverty, and occupation are recognized as environmental factors. Social and individual behavior patterns—smoking, alcoholism, tension, overeating, and sedentary life—have been associated with an increased risk to these chronic diseases, and constitute potentially modifiable societal activities. What is needed is better medical capability to deal more effectively with the chronic diseases as well as the acute illnesses and trauma.

The problem today then is one of lifestyle and education. We physicians traditionally are looked upon as healers and are trained to measure abnormality and deal with symptoms of disease entities. Patients have been geared to respond to symptoms and to rely on the physician's medical treatment for relief. These modes of behavior work very well when symptoms are apparent, but all practicing physicians know that chronic diseases with slow onset may not produce specific symptoms until the very late stages of illness. A patient who is without pain or discomfort would not be motivated to see a physician because he has never been educated to do so. Thus, cases of people who die suddenly of myocardial infarctions but have never been sick a day in their lives are not improbable.

The American life style complicates the problem significantly. Our "future is now" philosophy discourages the long term practice of preventive medicine, and the resultant good that might be achieved. The old adage, "You can lead a horse to water but you can't make him drink," applies. The physician can advise, but the patient does not always comply. Economic considerations also play a role, in that it

may be financially impossible for an individual to switch jobs, move to a new location, or afford a better diet. In a democratic society government involvement is warranted only when it can be shown that the actions of one individual infringe upon another. Therefore communicable disease laws resulted when the causes of infectious disease were clearly established. Although risk factors have been demonstrated for pulmonary, cardiac, and oncologic diseases, legislation mandating personal habit based upon questionable evidence would have precisely same effect as the Eighteenth Amendment.

Defining and implementing solutions for this dilemma will be difficult because they require altering societal attitudes. So much hope has already been attached to the "new" family practitioner that it is perhaps unfair to expect these physicians to assume the responsibility for preventive medicine. Yet logically, community medicine and public health professionals may be the ideal teachers of health maintenance. Public education regarding *probable* causal relationships between disease and social or environmental factors is a primary goal. To achieve this medical school curricula must include more emphasis on risk factors of disease and their control.

The observation of William Farr (1807-1883) is no less applicable today: "The great source of misery of



mankind is not their numbers, but their imperfections, and the want of control over the conditions in which they live . . . there is a definite task before us—to determine from observation the sources of health, and the direct causes of death in the two

sexes at different ages under different conditions. The exact determination of evils is the first step in their remedies."

David A. Smith, M.D.
Medical Editor

Mechanical delays impede membership efforts

The mechanism to induct new members into county medical societies is malfunctioning. According to a report given at Annual Session by the Council on Professional Relations and Services, delays of six months or more are reported in some cases from the time a physician expresses an interest in joining until he is accepted. At a time when membership recruitment is a priority, it would appear that membership entrance requirements need streamlining.

To date, only 14,000 of a possible 21,000 physicians licensed and living in Pennsylvania are members of PMS. Because the power and function of organized medicine depends heavily on the size of its membership, it is important that new members be recruited and entrance procedures expedited.

Chapter III, Section 14 of the model bylaws recommends that the county Board of Censors determine that the applicant is a fully licensed, reputable physician by making inquiry to the Biographical Department of the AMA, and to the State Board of Medical Education and Licensure. These inquiries can normally be made in less than six weeks. Many county societies, however, insist on conducting

supplemental investigations which delay the application process for three months and more.

Several county societies, for example, require that the applicant's name be published two successive times in the monthly bulletin, or that the applicant attend two consecutive meetings before his application can be accepted. Another county society requires a personal interview between the applicant and the Board of Censors. However, there is no evidence that these additional requirements significantly help in determining the qualification of a candidate for membership.

In our caution to keep out the "bad doctor," we may be losing members through the delay and neglect of worthy applications. This does not mean we should let down the gates. Instead, we should study our application procedures to eliminate unnecessary delays. A growing membership is essential to the success of the Society, but unless our entrance requirements are streamlined, recruitment efforts will be nullified by our own red tape.

Thaddeus Lekawa, M.D., Chairman
Committee on Membership Recruitment



correspondence

What's what in plastic surgery?

To the Editor:

The guest editorial by Dr. Frank I. Marlowe in the September 1976 issue of PENNSYLVANIA MEDICINE entitled, "Who's Who in Plastic Surgery" was excellent in emphasizing that many of the various surgical specialists perform plastic surgical procedures frequently and well.

It must be noted that such specialists are designated as specialists in their particular specialty, e.g., otolaryngologists, ophthalmologists, gynecologists, general surgeons, etc.

A "plastic surgeon" is an individual who has trained 4-5 years in a general surgery residency and another 2-3 years specializing in a plastic surgery residency. His practice is limited to plastic and reconstructive surgery and after proper examination he must be certified by the American Board of Plastic Surgery.

The various surgical specialists—otolaryngologists, orthopedists, ophthalmologists, etc.—who frequently perform plastic surgery procedures are not plastic surgeons and should not be so designated, even though these regional or system surgeons are capable of performing procedures which are referred to as "plastic surgical operations."

It is true that the number of "plastic surgeons" certified by the American Board of Plastic Surgery is not as large as the total of the other surgical specialists. The other specialists in their various fields have every right to continue to perform the surgery for which they are qualified, but it is not proper to designate them as "plastic surgeons."

The title "plastic surgeon" is reserved for those properly trained and certified by the American Board of Plastic Surgery.

George Manstein, M.D.
Philadelphia

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Government health care offers 'paper cure'

ABRAHAM J. TWERSKI, M.D.

Pittsburgh

*"Goto hell, Washington—
and take Harrisburg
with you!"*



Now I must introduce you to the Administrator of our hospital, a Sister of the Order of St. Francis. She has the conviction that Providence has placed her in charge of a large hospital in order to make sure that people in need of help receive it, with no ands, ifs, or buts. Regulations of whatever nature from whatever governmental sources that restricted provision of services had no meaning for her. If you knew you could help someone, then you helped him. Given the myriad of booby-trap legal technicalities that stood in the way of providing help for a mentally ill person, it is

fortunate for the people of Pittsburgh that Sister never took them seriously for so many years, and went on doing what had to be done. Financial considerations carried no greater weight than these legal technicalities, and before the days of government intervention, no one other than the comptroller was in the least concerned about hospitalization coverage. Patients were admitted and cared for according to their needs. From time to time, this policy resulted in the comptroller panicking about an impending financial crisis, at which time, Sister would somehow work her way

out of it until next time.

The hospital policy was one of an open door, and Sister was adamant that no one be refused help if only help could be provided. She respected a physician's decision, and would never overrule it, but had this one reservation. The authority to admit a patient could be given by phone; the decision to refuse admission had to be made in person. For example, the police might bring to the emergency room a man taken into custody for vagrancy, but instead of taking him into jail, they had decided to bring him to the hospital. Examination by the

'Go to hell, Washington, and take Harrisburg with you!' is the response of this author, a well known Pittsburgh psychiatrist, to the 'paper world' of government controlled medicine. He recounts his frustrating experiences in this, the third of a series of articles, as reprinted from the Pittsburgh Press.

physician in the emergency room would reveal no sign of physical or mental illness. If Sister was aware of the case, I would get a call at home about possibly admitting this man, because if he were put out on the street, he would have nowhere to go. I would object, stating that the hospital cannot be used as a refuge for the homeless, and Sister would respond that the man is probably emotionally ill, and that if after I examined him, I wished to send him out, she would have no objection.

I would come down to the emergency room, and after seeing this unfortunate person, I could no more put him out on the streets than she could, and of course she knew this would be the case. So in spite of the absence of any gross manifestations of mental illness, the man would be admitted, and during the next several days, a social worker would arrange for shelter with an appropriate community facility, and the man would be discharged. Sister felt that being a vagrant constituted a type of emotional illness sufficient to warrant psychiatric hospitalization, and that this was not misutilization of a hospital. She would not overrule my decision not to admit, after I interviewed the person, but I knew that she knew that I knew what would happen if I saw the person "in

person," rather than receive information by phone. Eventually I surrendered, and people were admitted with my telephone approval.

Understandably, this policy led to an enormous number of admissions, and a shortage of beds. There were many times when I left the hospital at the end of the day, with the admissions office staff completely bewildered because all the beds were full, and there were three patients in the emergency room awaiting admission. The following morning, I would discover that these three patients had been admitted, and on top of that there were four more patients admitted during the night, yet no one had been discharged. How this was accomplished is a mystery to me to this very day.

Meanwhile, the hospitals operated by the state government, noting that "holdover" patients were no longer in jail, but were being admitted to St. Francis, decided to employ another government tactic; namely, any time you can make someone else do the work, go to it. Somehow the word got around that all mental patients could be admitted to St. Francis for subsequent transfer to the state hospital, and this relieved the state hospital from dealing with many acute admissions. So instead of evening and weekend "holdover" services, St. Francis began to be used as an admission

ward for the state hospitals. **By the time I arrived at St. Francis, 70 percent of all state hospital admissions were processed through St. Francis, regardless of whether the patient presented at 3 a.m. on a Saturday morning or 2 p.m. Tuesday afternoon. It got to the point where a patient who had recently been discharged from a state hospital and requested readmission, had taken a bus and gone out to the state hospital one weekday morning. He was refused admission, and told he must go back twenty miles to the city and get admitted through St. Francis.**

In the early 1960s, there had been congressional studies of the needs for mental health care, and this culminated in a report, "Action for Mental Health," recommending establishment of community mental health centers throughout the country. In the heyday of enthusiasm for social welfare programs, Congress passed a bill and appropriated the funds for the establishment of community mental health centers.

The community mental health center movement deserves extremely serious scrutiny. It was an outgrowth of recognized deficiencies in mental health services, and was an attempt to rectify this situation. Psychiatric care was costly, psychiatrists were scarce, and waiting periods

for appointments were long. These conditions were due to the particular state of both physical psychiatric treatment and psychotherapy at this time, coupled by an enormous increase in awareness of psychiatric problems and demand for services following World War II. I doubt that anyone questions the need for action of some type. The response of introducing a governmentally administered health services program in this area should be considered a prototype of what a government response to other health care services might be.

The availability of federal funds appeared to be an opportunity to expand mental health services, and between myself and an associate, a blueprint for the first community mental health center in the area was worked out. Sister had some reservations about the idea, because the federal regulations appeared to limit services to a geographic "catchment" area, and she feared that this meant denial of services to some people because they resided outside the specified area. Any such limitation was anathema to her. She approved only after the federal agency involved assured us in writing that we would be permitted to provide services to anyone, as long as residents of the catchment area were given priority.

Then came the business of grant application, which was a new revelation for me. It became evident that Washington at this time was anxious to give away money. Apparently when Congress appropriates money for an agency, that money must be spent, otherwise the agency cannot ask for more the next time around. The representatives of the federal government we dealt with were more than cooperative in helping us prepare our grant proposal.

We hit a snag when we realized that the regulations required that we must provide five essential services: inpatient, outpatient, partial-hospitalization, 24-hour emergency services, and consultation and education. Furthermore, these services had to be provided for all age groups, children as well as adults. Because of the scarcity of child psychiatrists, we saw no way of providing all the required services for children. Nor could we see our way to implementing a partial hospitalization program at that time. We therefore presented these problems to the feds.

The feds came back with the reply that the partial hospitalization requirement could be fulfilled by a statement of intention to institute such a program within a "reasonable time." As far as the children's services were concerned, we could meet compliance by entering into a contractual relationship with another child-care facility to provide these services, and we did not have to provide them all ourselves. I pointed out to the feds that the latter was impossible, since there did not exist any children inpatient services in the entire city at that time, so that no one could provide these services by contract. Furthermore, the outpatient child care facility in the community was a 9 a.m. to 5 p.m. weekday operation, with a long waiting list for services, and could not pro-

vide either emergency services or outpatient services for our population. **The feds answered for us not to worry about this, only to provide the piece of paper showing a contractual relationship with a pediatric psychiatric service somewhere, and this would suffice for the grant purposes.** The fact that this piece of paper was meaningless in actuality was of no consequence.

It was here that I began to be aware of the "paper delusion" I previously ascribed to government. All you need to do to comply is to provide services on paper. No one gives a damn whether they exist or not. I wonder how many centers established under these federal guidelines and now in operation as *comprehensive* mental health centers provide the services they claim to, and how many are just outright liars, encouraged to lie by the federal government. If general medicine goes federal, what is to prevent promise of services which are undeliverable? I can envision a general medical clinic, alleged to provide services in all specialties, where compliance is by *paper* contract with other clinics, which are already oversubscribed by their own patients. Can you envision having an obstructed artery replaced by a phantom surgeon, who exists only on a piece of paper? □

(Continued next month)



education

This issue carries no education course listings. A comprehensive list of education courses being offered in all parts of Pennsylvania appeared in the September issue. Consult that issue or write for a copy of the supplement to: Council on Education and Science, Pennsylvania Medical Society, 20 Erford Road, Lemoyne, PA 17043.

Psychiatric society head critiques mental health act

MORTON JOHAN, M.D.
Pittsburgh

On July 9, 1976, Senate Bill 1025, now known as Act 143, was signed into law by Governor Milton J. Shapp. The final regulations have been published and most provisions of the Act have been in force since September 7, 1976. The remaining features of the Mental Health Procedures Act will go into effect January 7, 1977.

Morton Johan, M.D., is current president of the Pennsylvania Psychiatric Society. Dr. Johan maintains a practice in Pittsburgh and is an assistant clinical professor of psychiatry at the University of Pittsburgh School of Medicine. The Executive Council of the Pennsylvania Psychiatric Society reviewed this critique prior to publication.

Provisions of the Mental Health Procedures Act of 1976, Act 143

1. The Act "... establishes rights and procedures for all involuntary treatment of mentally ill persons, whether inpatient or outpatient, and for all voluntary inpatient treatment of mentally ill persons. 'Inpatient treatment' shall include all treatment that requires full or part time residence in a facility."
2. This Act requires formation and review of an individualized treatment plan for every person who is in treatment under the act.
3. This Act requires that the treatment team be under the direction of either a physician or a licensed clinical psychologist, but requires the team to be under the direction of a physician when: (1) failure to do so would jeopardize federal payments made on behalf of the patient; or (2) the director of the facility requires the treatment to be under the direction of a physician. Further, a physician must be on all teams for the purpose of administration of all drugs controlled by The Controlled Substance, Drugs, Device and Cosmetic Act.
4. This Act requires that to the extent possible, the plan (treatment plan) shall be made with the cooperation, understanding and consent of the person in treatment. "Before a person is accepted for voluntary inpatient treatment an explanation shall be made to him of such treatment, including the types of treatment in which he may be involved, and any restraints or restrictions to which he may be subject, together with a statement of his rights under this Act."
5. This Act requires that the Department of Public Welfare "shall adopt such rules, regulations and forms as may be required to effectuate the provisions of this Act." In doing so, the department has created over twenty such forms and documents, most of which must be sworn to and carry the following statement in bold type: "Any person who provides any false information on purpose when he completes this form may be subject to criminal prosecution and may face criminal penalties including conviction of a misdemeanor."
6. This Act requires that "Whenever a person is severely mentally disabled and in need of immediate treatment, he may be made subject to involuntary emergency examination and treatment. A person is severely mentally disabled when, as a result of mental illness, his capacity to exercise self-control, judgment and discretion in the conduct of his affairs and social relations or to care for his own personal needs is so lessened that he poses a clear and present danger to others or to himself. Clear and present danger to others shall be shown by establishing that within the past thirty days the person has inflicted or attempted to inflict serious bodily harm on another and that there is reasonable probability that such conduct will be repeated." In cases when a person has been found incompetent to be tried or acquitted by reason of lack of criminal responsibility on charges of inflicting or attempting to inflict bodily harm on another, a clear and present danger may be shown by establishing that the conduct charged did occur and there is a reasonable probability that such conduct will be repeated. Clear and present danger to himself shall be shown by establishing that within the past thirty days: the person has acted in such a manner that he would be unable, without care, supervision and assistance, to satisfy his need for nourishment, personal or medical care, shelter, or self-protection and safety, and that there is a reasonable probability that death or injury would ensue within thirty days; or the person has attempted suicide and there is a reasonable probability of suicide; or the person has severely mutilated himself or attempted to mutilate himself severely and that there is a probability of further mutilation. The following provision, previously included in the legislation was deleted prior to passage: "The person's behavior, without rational explanation, has abruptly changed in that he is recklessly wasting his assets, and that there is the present likelihood that he will continue such conduct unless adequate treatment is afforded under this Act."
7. This Act requires that all applications, petitions, statements and certifications shall be filed with the county administrator where the person was made subject to examination and treatment and such other county in the Commonwealth, if any, in which the person usually resides. This Act requires that all documents concerning persons in treatment shall be kept confidential and without the person's written consent, may not be released or their contents disclosed to anyone except: (1) those engaged in providing treatment for the person; (2) the county administrator.
8. This Act establishes procedures for the conduct of informal hearings for determining conditions of treatment, etc. within three days.
9. This Act, by procedure, restricts a patient entering a state hospital or similar facility directly, except by prior agreement.

That last portion deals only with those involuntarily committed patients who are now confined in mental hospitals.

The Mental Health Procedures Act is of most vital interest to psychiatrists, but it will also be of special interest to primary care physicians such as family practitioners, internists, and pediatricians. Because the care of the mental patient is intimately connected with public policy and, therefore, governed by statute and regulation, the psychiatrist and his patient are likely to have more involvement with the agencies of government than most other practitioners. Because our specialty is in the forefront of the contact with government, those matters of relationship to government which now affect the psychiatrist may soon in the future affect the entire medical profession.

The only phase of the diagnosis, treatment, and care of the mental patient that is not affected by this statute is private office practice. Clinical practice, community mental health center practice, hospital practice, whether private or public, voluntary or involuntary, are all affected by this law.

While there are a few things which might be written in praise of this law, for the most part it is a bad law for our patients, bad for the practitioner, and bad for the hospitals. Approximately four years ago, an omnibus-type bill was suddenly proposed in the Commonwealth to which the Pennsylvania Psychiatric Society took strong objection. As a consequence of our objection, there were numerous meetings of an ad hoc committee composed of members of the Pennsylvania Psychiatric Society, members of the legal profession, representatives of the Legislature, and representatives of and consultants to the Department of Welfare.

As a result of the work of that ad hoc group, there were a number of changes. One of those changes was the breaking up of that omnibus bill into at least two components, one of which is the Mental Health Procedures Act. Nevertheless, our professional input has had scarcely more than minimal effect on the substance of this Act and its administrative regulations.

The foremost objection which we have to this law is its intrusion into the privacy and confidentiality of the doctor-patient relationship, especially in the care of the voluntary patient. This law requires that in the case of *all* voluntary patients admitted to hospitals (state hospitals, private mental hospitals, psychiatric units in general hospitals) their admission be reported to the administrator of the county mental health and mental retardation program. Their discharge from the hospital is also to be reported to the administrator. We cannot understand why this should be the law of the Commonwealth. It

would be equally justified for all patients hospitalized for peptic ulcers to be reported to a governmental authority. This reporting has little to do with census taking or statistics of the incidence of mental disorders. Because of this record keeping and other tasks and because of the vast authority of the county administrator, it is impossible to conceive of this statute and the regulations as anything other than establishing governmental control. While it is no doubt impolitic to say, the title "Commissar" would seem more fitting than county administrator. Compliance with this law will require enormous record keeping, a host of employes, and invasion of privacy.

In the name of protecting the rights of patients, the Act requires many Department of Welfare forms. These departmental forms will discourage patients from accepting treatment. When they do accept treatment, hospital stay is likely to be lengthened and additional personnel will be needed to manage the record keeping. While patient's rights must be protected, the departmental forms impede care and cast the hospital and medical staff in an adversary position vis a vis the patient. The law further requires that within a 72 hour period, a treatment program be formulated by a multidisciplinary treatment team including the patient. Psychiatrists have been in the forefront of promoting multidisciplinary treatment teams, but can you imagine a patient admitted to a hospital with complaints referable to his lower bowel. A multidisciplinary treatment team plans the diagnostic and treatment procedures. The patient is asked not only for his informed consent to proceed but for his opinion about the wisdom of the procedures. I am sure that the majority of patients expect privacy in their treatment, expect to be informed about the treatment, but also expect that the treatment will be planned by the physician that he employed. In addition to that gross invasion of privacy, in these days of concern for proper utilization of hospital beds, these procedures will undoubtedly increase the length of patient stay, not for treatment as much as in order to comply with the governmental regulations. It is not enough that you explain to your patient and to his relatives at your office that you advise hospital treatment and that you propose one or another treatment. You must do it "by the book;" on a government form listing the patient's symptoms, a form which the patient must sign. (Patients are always referred to as "clients" on these forms, an apt term when one surveys the legalisms on the forms, more appropriate to a bill of sale than to a medical document). Not only do we object to this invasion into the confidentiality of our relationship with our private-paying patients, we are unable to understand why there should be an inva-

sion into the privacy of the medicaid and medicare patients. The government has a right to know that its money is honestly and well spent. But such involvement and prescription of treatment management dictates how the money is spent. It does not inquire. I feel confident that if this provision of this law is not changed rapidly by legislative amendment, that it will be brought down in the courtroom but only after many unfortunate weeks and months.

To the extent that this Act deals with involuntary patients, it is in accord with numerous recent judicial decisions in both Pennsylvania and other states. While we cannot object to that, we do feel that it is a regression to the state of affairs 50 years ago. At that time, in virtually every state in the Union, a patient was committed to a mental hospital after a court procedure modeled after criminal proceedings. Gradually this legalistic procedure was lessened but now it has returned full force. Patients can be involuntarily committed only if they are proven to be dangerous to themselves or others. The description of the dangerousness is spelled out in the law and the regulations. We did succeed in convincing the legislators that a person might be dangerous to himself simply because he does not take care of his basic needs. But the law specifies that this disregard of basic needs must be so severe that death can be expected to occur within 30 days.

The primary problem with involuntary commitment has been the indeterminate length of that "regular" commitment. This Act corrects that old fault. However, we feel that new problems are being set up. After the maximum period of 90 days, the patient must again go to court and be proven to be dangerous to himself or others. While there is much to be said for these procedures, it must also be said that large numbers of patients whose treatment failed will have to be discharged from hospitals. No plan has been made for them. It is assumed that community mental health centers can take care of the matter. This new commitment and discharge procedure is a matter of public policy. While the Pennsylvania Psychiatric Society might regret some of the particulars of that policy, we know that involuntary commitment has always been more of a social decision than a medical one. However, it will be difficult for physicians to live easily with this. Families will come to you asking for help to get a relative into a treatment setting. They will tell you that the patient cannot be persuaded to accept treatment and they will ask you to compel him to get treatment. The families will continue to believe that the doctor has such authority. We never did. Now it is very explicit and the limits of our authority are clearly spelled out and limited. It will be necessary to say to the families that they should seek redress from pub-

lic authorities. Perhaps the most glaring deficiency in the law's description of "severe mental disability" (the words for committable) is that it cannot encompass the manic patient. The manic patient who by reason of his grandiosity often does things which will embarrass him or his family or might deplete his financial resources, will, under this law, be looked upon merely as a fool, not as a sick person.

There are some good features of this bill. Act 143 does specify better procedures for handling people charged with criminal conduct who may also be mentally sick. The Act does clarify the treatment of juveniles. These provisions for the juvenile seem sensible and in this instance, our professional input was most influential.

Regardless of the specific provisions of the Mental Health Procedures Act, it is hard for the physician to read it and to have worked in its formulation without feeling that there is a very substantial anti-physician bias. While we recognize the need for the protection of the rights of patients including their civil liberties and while we recognize that in the Soviet Union and elsewhere, psychiatrists have probably lent their professional services to the government for political control, throughout one reads between the lines that the doctor is not too trustworthy. A patient should know that he can seek legal redress from involuntary commitment but this law requires that he be immediately informed of that fact before the initial examination commences. In an early version of the bill, when provision for immunity was written (that is, immunity from civil or criminal proceedings if the hospital or institution staff acted in good faith) the various professions who were granted immunity were enumerated but the physician was omitted. He was presumably covered under the word "other." It is true that our protests brought prompt rewriting even though the writers thought we were unduly suspicious and narrow minded. After many rewritings of the bill, a provision was written in at the last moment that the multidisciplinary treatment team could be led by a physician or licensed clinical psychologist. The law bill previously stated that the physician must be in charge if the director required it or if the institution or the Commonwealth would lose federal funds by not having a physician in charge of the team. The Pennsylvania Psychiatric Society took violent exception to this but we were not even granted the privilege of a hearing.

In summary, this law needs to be revised by numerous amendments. If amendments cannot be achieved, it seems quite clear that there will be litigation in the courts. While we await these changes, much hardship will be created for patients and families.



Do you really need a multi-office practice?

LEIF C. BECK, LL.B.

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Bala Cynwyd

There are few advantages and innumerable disadvantages to practicing out of more than one office. Some considerations and problems involved are detailed in this article. We hope it will serve as a guide for those physicians presently operating out of more than one office, and for those considering such a step.

Higher overhead

The overhead of a multi-office practice is generally substantially higher than that for a single-office practice of similar size and specialty.

This is primarily caused by the inefficiencies and duplication of such an arrangement. Generally, personnel and rental costs are the biggest areas of extra expense in a multi-office arrangement. However, equipment, furnishings, and the like must often also be duplicated at all locations. The items all add to overhead without necessarily generating more income than a well-planned and centrally located single office might.

For example, some time ago we surveyed a solo practitioner with two offices. His rental overhead figures as a percentage of his gross income were almost twice as high as the national averages for his specialty, even though his gross income was close to that of the averages. In other words, he was spending twice as much for rent to generate the same income as his peers. This forced a critical evaluation of the importance of the two offices, and it was finally decided to drop one of them. His net income was not affected by the move, and he is now practicing at a less harried pace.

Coordination problems

The most common problem of a multi-office practice is that of coordination. Although it affects multi-office practices of all sizes, this problem hits smaller groups and solo practitioners hardest.

Equipment needs—One or more of a practice's offices are commonly inadequately equipped. For example, a solo cardiologist we are acquainted with had a "stress test" machine in only one of his two offices. His practice could not as yet afford a second one, but the inconvenience caused to him and his patients by not having it readily available was great. His patients who had appointments at that office

and who needed the test were either required to schedule another appointment at his other office or go elsewhere for the test. This is only one example of circumstances where one or more of a practice's offices were inadequately equipped clinically and caused inconvenience, disruption, and annoyance to the physicians, staff, and patients alike.

Many multi-office practices also lack certain nonclinical equipment at each location. For example, a practice may not have a separate copying machine in each office for good financial reasons even though the lack may cause inconveniences and delays.

These points do not suggest that each office should have all items of equipment since the cost can be too high. It merely indicates some of the inadequacies of the multi-office arrangement and the greater need for management and coordination under such circumstances.

Scheduling of patients—Solutions to scheduling problems turn upon circumstances unique to each particular case (e.g. type of practice, relative location of the offices, number of doctors involved, volume of patients, etc.).

The following illustration shows how a three-doctor Ob/Gyn practice, with two offices approximately four miles from each other, handled the situation. Gyn patients were allowed to select one of the two offices as "primary office" and were to be seen there at all times except for emergencies. All obstetric patients were required to be seen at only one of the two offices. Adoption of this system helped the practice avoid most of the disruptions rampant in a more loosely run multi-office arrangement. These include chart filing, telephoning, and the like, to be discussed more fully below.

Such schedule coordination also helped facilitate that office's handling of blood work. For example, a system was established whereby all blood (lab) work would be picked up and distributed to the office where the patient's chart is located. This "obvious solution" is one that several offices had not previously used and is but one example of what can be done to help things run more smoothly.

Dealing with medical charts—The handling of medical charts is often frustrating to a multi-office practice. Little can be more annoying to the doctor,

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patient, and staff than not to have the chart readily available during an office visit or telephone discussion "because it is in the other office." Although there is no guaranteed and perfect solution, some sound planning can help diminish such annoyances in any practice.

For example, the above mentioned Ob/Gyn group established separate filing systems in each office (Gyn by patient preference and all Ob in one office). The impact was dramatic. Proper patient education regarding the change (e.g., by a patient information booklet) and sound implementation by the practice (by following the established rules) is what is needed to deal with such matters.

Centralization of business functions—We strongly believe that a practice is best served by centralizing all business functions (particularly billing, collections, and checkwriting) in one location. Once again, the primary goal is to avoid disruptions, inefficiencies, and duplication. The preparation of insurance forms may be another matter, depending upon the closeness of the offices and the ease with which information can be transported from office to office. This is particularly true since patient charts are needed to complete the forms. The thought of transporting these charts to the "central insurance office" could cause more problems than it avoids since it will defeat the concept of keeping each medical chart in its own office.

Once such a business office is established, it is usually wise to add a separate phone line or lines ringing directly to the business office. By imprinting that office's address and special telephone number(s) on all billheads, appointment cards, patient receipts, patient information booklets, and the like, all patients should come to understand that inquiries or problems regarding insurance and/or bills should be so directed. The arrangement would also avoid tying up the other practice lines. As patients get used to calling that number for such matters, the calls will bypass the receptionist and free up her time.

Telephone handling—Generally, it is advisable to have an inter office telephone line to allow prompt and uninterrupted contact among offices. The only situation in which this idea might not apply is if the price of such special lines should be prohibitive as compared to the cost of direct dialing between offices.

Also, each office should have a separate telephone number to even more fully indoctrinate patients to "their office," while of course making the other number(s) available for emergencies, etc. This is especially true if it would otherwise be a toll call (or heavy message unit call) for local patients to call the other office number.

Managerial needs

Office management—Depending on the size and nature of the practice and the number of physicians involved, a multi-office practice may be best served by the hiring of a lay administrator, either an assistant who has worked up through the ranks, or one hired from outside the practice, to coordinate practice matters. Basically this person's role would be to consider and deal with the day-to-day problems for which active physicians are too busy but which are inherent in each of the separate offices.

Personnel management—An especially important aspect of a properly run multi-office practice involves the proper handling and use of personnel.

If an office manager is involved this will be one of his or her primary functions. If there is no office manager, then a doctor must take the responsibility, particularly in the areas of scheduling and job assignment.

An important part of a cohesive "team effort" are regularly scheduled, best if at least monthly, office staff meetings. These provide everyone with the opportunity to discuss any hang ups which may arise in the multi-office arrangement and use the "team approach" in seeking out ways to deal with them.

A multi-office practice can be fraught with difficulties not found in a single office practice. For example, it is important to coordinate pay scales among the various offices' employees to avoid dissension in the ranks. Further, a coordination of employee working hours should be attempted. Because some of these problems may be unavoidable, it is important that open communication and goodwill be maintained with all employees to help avoid hard feelings.

Need for strong audit controls

Multi-office practices may have particular difficulty in dealing with cash controls in all offices. There may, for example, be a casual transporting of money from one office to another. These sometimes require an assistant to take money and financial records home overnight while transporting those valuables from office to office. Such circumstances leave a practice wide open for embezzlement, as well as theft, fire, and other loss.

The solution once again turns upon the size of the practice, the distance between offices, and the number of employees involved. Multi-office practices should inform their management advisors of any such situations, so that close scrutiny during audits can be planned.

Generally, it is advisable to bond money-handling employees. A "blanket bond" covering all employees dealing with money is usually best as opposed to a bond specifically covering only some employees. The bonding is even more strongly called for when sev-

eral offices are involved.

Patient information booklet

A patient information booklet can serve many useful purposes in patient education. In a multi-office practice it can be especially helpful in setting forth scheduling procedures, instructions regarding billing (e.g. central business office idea), telephone policies, medical chart filing locations, etc.

Its use can save office staff and patient time. Furthermore, it is a courtesy to patients, to help them avoid confusion, since it clearly sets forth a practice's policies.

Why have more than one office?

As may be evident from our comments, a multi-office arrangement is often not most desirable. Many more problems are involved than are present in a one office situation. However, we recognize that many multiple office arrangements are for good and valid reasons (serving patients better, developing a sufficient practice base, dealing with a merger of existing practices, and the like).

Some practices have been operating that way for years and some newly organized practices have

been set up that way out of fear that one office alone will not provide adequate support. We have found that most presently existing multi-office arrangements are valid and should be continued.

We submit that many of those practices would find, perhaps surprisingly to the physicians involved, that their net incomes would not drop if they practiced in one office (due to higher overhead caused by duplication, inefficiencies, etc.).

Therefore, we strongly recommend that complete accounting records be kept regarding the production, receipts and expenses of each office to determine each one's respective profitability. By reviewing such statements, which should be prepared monthly, trends may become evident and the respective profitabilities will be objectively reviewable in evaluating the multi-office arrangement.

Conclusion

This article does not solve all of the problems of a multi-office practice. Many are insoluble and others require different solutions in each instance. However, we hope it proves helpful by raising many of the difficulties involved and how they affect the desirability of such an arrangement. □

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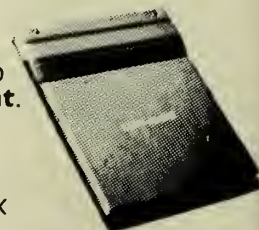
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obituaries

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• **Edwin P. Albright**, Philadelphia; Temple University School of Medicine, 1941; age 61; survivors and exact date of death are unknown at this writing.

• **Herbert W. Barron**, Graterford; Hahnemann Medical College, 1932; age 69; died August 18, 1976. His wife and four daughters survive him.

• **Frederick C. Brady**, Pittsburgh; Jefferson Medical College, 1939; age 63; died September 10, 1976. He had been a staff member of Mercy Hospital since 1939 and had served as chief of surgery, director of the outpatient clinic, and director of surgical teaching. He was clinical professor of surgery and director of the applied anatomy post-graduate course for the University of Pittsburgh School of Medicine and chief of surgical services at Mayview State Hospital. He was a past president of the Allegheny County Medical Society, from which he received the Frederick M. Jacob Physician's Merit Award, the Pittsburgh Surgical Society, the Pittsburgh Academy of Medicine, the Southwestern Chapter of the American College of Surgeons, the Allegheny County Chapter of the American Cancer Society, and the Allegheny County Council on Emergency Medical and Health Services. His wife, three daughters, two sons, one of whom is Frederick C. Brady, Jr., M.D., and his mother survive him.

• **Burton Chance, Jr.**, Philadelphia; University of Maryland School of Medicine, 1938; age 64; died September 6, 1976. He had been executive medical director of the Home of the Merciful Saviour for Crippled Children since 1964. In recent years, he had specialized in the care of cerebral palsied children. His wife, two daughters, and a sister survive him.

• **Ralph M. Christie**, Butler; University of Pennsylvania School of Medicine, 1918; age 84; died August 12, 1976. He was a past president of the Butler County Medical Society and had practiced medicine in Butler since 1939. He is survived by his wife, a daughter, and a son.

• **Robert R. Clark**, Pittsburgh; University of Michigan School of Medicine, 1926; age 78; died September 5, 1976. He had been an instructor and later assistant professor of internal medicine for the University of Pittsburgh School of Medicine from 1927 to 1952 and had been on the staff of St. Francis General Hospital. At the time of his retirement he had practiced medicine for 40 years. His wife, a daughter, and a son survive him.

• **Edward H. Copper**, Lancaster; Howard University College of Medicine, 1944; age 60; died September 11, 1976. He was on the staff of St. Joseph Hospital where he was chairman of the utilization committee, was a deputy coroner for Lancaster County, and had practiced medicine in Lancaster 26 years. His wife, father, and step-mother survive him.

• **Richard A. Crandall, Jr.**, Harrisburg; University of Pennsylvania School of Medicine, 1950; age 50; died August 11, 1976. He was a founder and the first president of the Central Pennsylvania Psychiatric Society, a fellow of the American Psychiatric Association, and a member of the Philadelphia Association for Psychoanalysis. His wife, two sons, two daughters, his father, and a sister survive him.

• **James J. Dusckas**, Erie; University of Pittsburgh School of Medicine, 1937; age 64; died August 24, 1976. His wife survives him.

• **Thomas R. Fister**, Paupack; New York University School of Medicine, 1935; age 70; died August 7, 1976. He was a radiologist for Wayne Memorial Hospital in Honesdale, the Hemlin Clinic, and the Wallenpaupack Area Medical Foundation, Tafton. He is survived by his wife, three daughters, and his mother.

• **John L. Gemperlein, Jr.**, Ford City; University of Pittsburgh School of Medicine, 1952; age 51; died August 20, 1976. He was a pathologist in the Armstrong County Memorial Hospital. His wife, six sons, eight daughters, and two sisters survive him.

• **Simon B. Glick**, Reading; General Medical College, Chicago, Illinois, 1917; age 85; died August 14, 1976. He had served as a Berks County coroner 1932-36, then as a deputy coroner until his death. Until retirement in 1961, he was on the staff of the Community General Hospital. Surviving are his wife and two sons, one of whom is Charles L. Glick, M.D.

• **Henry E. Helling**, Ellwood City; University of Pittsburgh School of Medicine, 1909; age 93; died August 8, 1976. He had practiced medicine in Ellwood City for over 60 years. A daughter survives him.

• **Elizabeth M. Hughes**, Philadelphia; age 86; died July 30, 1976. A sister survives her.

• **C. J. Kleinguenther**, Blakeslee; Hahnemann Medical College, 1933; age 66; died July 29, 1976. His wife, two sons, and a brother survive him.

• **John S. Large**, Erie; University of Pennsylvania School of Medicine, 1938; age 63; died September 19, 1976. His wife survives him.

• **Gottlieb S. Leventhal**, Philadelphia; Jefferson Medical College, 1927; age 74; died August 17, 1976. He was a former instructor and associate in orthopedic surgery at the University of Pennsylvania School of Medicine, former clinical professor of orthopedic surgery at Hahnemann Medical College and Hospital, and former chief of or-

• Indicates membership in the Pennsylvania Society at time of death.

thopedic surgery at Albert Einstein Medical Center, Daroff Division. His wife, a son, Howard Leventhal, M.D., a daughter, and two brothers survive him.

• **Louis Margolis**, Wyncote; University of Vienna, Austria, 1938; age 65; died August 31, 1976. He was assistant clinical professor of medicine and head of the allergy clinic at the Medical College of Pennsylvania, and was an emeritus staff physician at the Albert Einstein Medical Center, Northern Division. A diplomate of the American Board of Allergy and Immunology, he was a fellow of the American Academy of Allergy, American College of Allergy, and the American Association of Certified Allergists. His wife, a son, Stephen Margolis, M.D., a daughter, and three sisters survive him.

• **Carlisle E. McKee, Jr.**, Pittsburgh; University of Pittsburgh School of Medicine, 1937; age 63; died August 31, 1976. His wife, a daughter, a son, a sister, and a brother, Claude W. McKee, M.D., survive him.

• **Horatio B. Miller**, Carmichaels; Jefferson Medical College, 1938; age 64; died August 10, 1976. He was president of the Greene County Medical Society from 1969 to 1972. He had practiced in Crucible, Rices Landing, and Carmichaels for 35 years. Surviving are his wife and a daughter.

• **Francis J. O'Malley**, Pittsburgh; University of Pittsburgh School of Medicine, 1929; age 71; died August 15, 1976. He was an orthopedic surgeon on the staffs of Children's, Homestead, and Braddock General Hospitals. His wife, a daughter, and three sons, one of whom is Donald F. O'Malley, M.D., survive him.

• **Robert E. Roscoe**, Harrisburg; University of Pennsylvania School of Medicine, 1949; age 50; died September 22, 1976. He had practiced internal medicine for 24 years. His wife, a son, three daughters, his mother, two brothers, and three sisters survive him.

• **Gilmore M. Sanes**, Pittsburgh; University of Pittsburgh School of Medicine, 1937; age 64; died August 16, 1976. He was president of the Allegheny County Medical Society in 1966, served as editor of the county medical society *Bulletin* from 1963-74, and was a member of the Board of Directors in 1963 and 1967. He was a member of the State Society's Committee on Medical Education 1963-67, and the Committee on Constitution and Bylaws 1965-66. He was chief of the departments of thoracic surgery for West Penn, Montefiore, and Pittsburgh Hospitals, and an associate in thoracic surgery in Presbyterian-University Hospital, Pittsburgh. He was the recipient of the 1969 Frederick M. Jacob Physician Merit Award of the county medical society. His wife, a son, who

is Gilmore M. Sanes, Jr., M.D., and two daughters survive him.

• **John L. Shearer**, McKees Rocks; University of Pittsburgh School of Medicine, 1943; age 59; died August 20, 1976. He was a charter fellow of the American Academy of Family Physicians and a fellow of the American Geriatric Society. He was on the staffs of St. John's General Hospital and the Ohio Valley Hospital. He is survived by his wife, a son, and a daughter.

• **Edmund B. Spaeth**, Philadelphia; University of Buffalo School of Medicine, 1916; age 86; died August 18, 1976. He was emeritus professor of ophthalmology and former chairman of the department at the University of Pennsylvania Graduate School of Medicine. He served as a consultant at Wills Eye Hospital, the U.S. Navy Hospital, and the Graduate Hospital of the University of Pennsylvania. His wife, four sons, and a sister survive him.

• **Harry B. Thomas**, York; Jefferson Medical College, 1929; age 72; died August 18, 1976. He was a past president of the York County Medical Society. He had been associated with the York Hospital since 1931, serving as chairman of the department of medicine from 1947 to 1961 and chief of metabolic disease from 1937 to 1970. A diplomate of the American Board of Internal Medicine, he was a fellow of the American College of Physicians. His wife and two daughters survive him.

• **Arthur J. Wise**, Souderton; Hahnemann Medical College and Hospital, 1933; age 72; died August 15, 1976. He was a former chief of obstetrics at Grand View Hospital in Sellersville and had practiced obstetrics for 35 years. Surviving are his wife, a son, Arthur J. Wise, M.D., a daughter, a sister, and four brothers.

• **Benjamin J. Wood**, Sharon; University of Pittsburgh School of Medicine, 1938; age 61; died July 30, 1976. He was national medical director and a member of the board of the Protected Home Circle Life Insurance Company (now Protected Life). He was a past president of the Mercer County Medical Society and the Pennsylvania Allergy Society. He is survived by his wife, five sons, a sister, and a brother.

Philip A. Giunta, Malvern; Georgetown University School of Medicine, 1968; age 34; died August 17, 1976. He was associated with the Delaware County Memorial Hospital, Upper Darby. Surviving are his wife, three daughters, his parents, a sister, and a brother.

John Shevlin, Carbondale; Hahnemann Medical College and Hospital; died September 18, 1976. A brother survives him.

Review of developmental screening in Pennsylvania

THEODORE B. COHEN, M.D.

Narberth

Up until now, child psychiatry has focused mainly theoretically on the 0-6 year old child. Early and periodic screening, diagnosis, and treatment (EPSDT) represents a reversal to doing first things first. For several years former presidents of the Regional Council of Child Psychiatry have worked with the Pennsylvania Office of Mental Health Task Force on Children and Youth on the writing of a prevention and treatment program for all Pennsylvania children 0-21 years.¹

Medicaid Title XIX of the 1965 amendments to the Social Security Act of 1935 provide that all recipients of categorical assistance were to receive basic health services with the payments made directly to the providers of service, called vendors.

In 1969, amendments (Section 7953.11(c) developmental examination to assess gross and fine manipulations, speech, adaptive social, and personal functions) were passed which included the early and periodic screening, diagnosis, and treatment of physical and mental defects in children eligible for Medicaid. The amendments involved approximately 13 million poor children under the age of 21, or 300,000 in Pennsylvania, and 1 out of 4 in Philadelphia. Medicaid does not operate clinics. It is a payment system, not a health care delivery system. The health and mental health delivery system is geared to treat illnesses, not to practice prevention.²

In 1972 Congress passed additional amendments which imposed a penalty of 1 percent of the state's federal allotment for Aid to Families with De-

pendent Children for those states that did not implement the EPSDT by September 30, 1974. The financial penalty (\$1 million in Pennsylvania, and \$1.9 million in California) is responsible for the present pressure to screen poor children.

As of January 1974 screening and evaluation services in Pennsylvania were extended to persons under 21 who are receiving public assistance payments or supplemental security income. Testing has been widely inaugurated in the Philadelphia and Pittsburgh areas, and at this writing 113,000 children have been evaluated.

A significant increase in funding for education of the handicapped, the education amendments of 1974 (ESEA) were signed into law in Au-

gust 1974. A vital feature is the Mathias amendment for aid to the handicapped, a 1 year funding measure which raised the authorized level of grants to the states for education of the handicapped from \$47.5 million annually to \$630 million. The expanded funding occurred in the wake of a series of state court decisions upholding the constitutional right of handicapped children to appropriate education. Today, 48 states have mandatory laws regarding public education of the handicapped. Infant EPSDT screening could be expanded to Headstart programs. Bucks County (1970) screening and the Vineland test of school children to age 12 and other methods, to age 21, could extend EPSDT through the school years and beyond.

The mental health screening of children has been stimulated by recent experiments by psychoanalysts in the first year of an infant's life. Reuben Kron,³ at the University of Pennsylvania, and Dov and Malca Aleksandrowicz,⁴ of Topeka, using Brazelton Test,⁵ have been able to select the ego defective and more severe, developmentally arrested children in the first few days of life. Their experimental work fits in with a national psychoanalytic effort toward studying vulnerable, very young children. Anna Freud^{6,7} turned our attention to developmental lines and the need for careful diagnostic evaluation prior to decisions about treatment. Miss Freud's work has aided our understanding of the developmental needs of vulnerable children.

The purpose of a general health



Dr. Cohen is a psychoanalyst in private practice. He is chairman, Subcommittee on Children and Youth, Pennsylvania Comprehensive Committee for Mental Health Planning, Department of Public Welfare, and chairman, Vulnerable Child Discussion Group, American Psychoanalytic Association.

screening program is to identify children with hidden health problems or needs that have not been recognized or treated and to ensure that the problems receive attention. The aim of developmental screening is to identify children who have significant deviations in psychological, neurological, or emotional development. EPSDT, under medicaid, is designed to find hidden problems in children from poor families with evidence of neglect and/or child abuse. The tests determine whether a child is at high risk, that is, has an environment dangerous to his internal development. It is also important to know the child's level of vulnerability, determined by constitutional factors or birth defects.

Children with low vulnerability and low risk are quite unlikely to develop problems. The more elaborate and costly diagnostic procedures could be used to determine which of the children of high risk and/or high vulnerability actually have needs and problems which have not been met, the exact nature and extent of the problems, and the treatment of choice.

In an HEW study, February 1974, only 46 percent of children's abnormalities were subsequently treated. Treatment is not automatic. In a recent report from California, 80 percent referred received followup and 77 percent were seen within 1 month of screening.

The internal neuroses are amenable to specific therapy. However, for the ego defective and developmentally arrested child, the chief objective is guidance for the child and the family to maximize the developmental potential, provide proper educational placement, and prevent the occurrence of secondary problems. With an ego defective child, siblings as well as parents need help in dealing with the psychological defenses of the ill child. Many ego defective and developmentally arrested children are not "curable" in the traditional sense, but require continuing medical management and other forms of help over years or a lifetime. An important function of repeated periodic screening visits is to ensure that the child and family have continued to obtain needed services

for chronic health problems. All families, whether or not their child has had any problems, should be given preventive counseling and education on how to maintain a healthy psychological atmosphere in the home.

If facilities, personnel, and funds are not immediately available to provide necessary diagnosis and treatment, screening may create anxiety and discontent in persons found to need such treatment. In many communities resources for evaluation and treatment of children with emotional problems and learning disorders are already overstrained. In the absence of such services, screening may be indicated only to demonstrate the need for services and to provide impetus for their development. Training our own "barefoot doctors" and establishing liaison between the Pennsylvania centers of professional expertise and the rural areas offer us exciting possibilities for the next generation of child specialists.

The method of screening recommended by HEW (1974) is a two stage procedure for infants and preschool children. The first is a history questionnaire given at all health appraisals and the second, a more accurate developmental screening test, such as the Denver Developmental, at 9 months, 3 years, and 5 years. Only 2 states, Pennsylvania and California, are using developmental screening now. According to William K. Frankenburg,⁸ a pediatrician who developed the Denver Developmental, "a child showing a developmental lag should then be given a thorough medical, psychological, and neurological evaluation."

All states should have formal evaluations. A history of a complicated pregnancy, a premature birth, small size for gestational age, maternal infection, a family history of developmental disabilities, or the presence of birth defects can alert the tester to high vulnerability. Specific questions can be asked about such a child at each health supervision visit and the child can be evaluated with a developmental screening test at 6 and 12 months, and at 2 and 3 years.

According to the HEW pediatricians (1974), developmental disorders including mental retardation,

seizure disorders, neuromotor disabilities, and learning and emotional problems afflict almost 17 percent of American children. This conservative estimate tabulates 3 percent mentally retarded, 0.6 percent psychotic, 3 percent severely disturbed and 10 percent with less severe emotional problems. This is about half the incidence found in studies by Stennis^{9,10} and Colarruso,¹¹ screening over 30,000 children in 7 states by the Bucks County method of teacher screening. Their figures were 5 percent ego defective, 30 percent developmentally arrested, and 65 percent normal or having internal neuroses. In Texas, mass screening of 3 year olds for learning disabilities found 25 percent had handicaps requiring remediation.

EPSDT is a state administered program. Many of the decisions which determine its effectiveness, such as payment schedules, billing and reporting mechanisms, and eligibility standards, are made on the state level. Each state has an advisory committee. Rhea Weiss, representing Children and Youth Services in the Pennsylvania Office of Mental Health, is trying to bring mental health input to the committee. To bring us up to date, she has summarized some present HEW conclusions on the EPSDT:

1. Of abnormalities in children, 76.3 percent are newly documented;
2. Children who have had continuous care in the past have fewer abnormalities;
3. The more thorough the screening, the more serious are the problems found;
4. As screening tests are given more periodically, outpatient costs increase, reflecting increased clinic use and decreased number of patients needing hospitalization.
5. The key to convincing a parent to bring a child for EPSDT was personal outreach and not movies. Under personal outreach, 98 percent came in for screening.

Two Pennsylvania organizations are screening at present: the Philadelphia Health Management Corporation, Philadelphia, and the Health Screening Research Foundation, Pittsburgh. As of October 1974, 27,820 children had been screened,

and 9,910 abnormalities had been found needing treatment. In the Philadelphia area a total of 587 developmentally aberrant children were found, compared to 598 in the western area. The following problems were found in the Philadelphia children: neuropsychological, 44; mental, 79; fine motor, 92; gross motor, 89; behavioral, 126; speech, hearing, and language, 157. Based on these figures, the screening picked up 4.2 percent of the children as having developmental problems.

By May 1975, 74,797 children had been screened in Pennsylvania, 14 percent of whom had developmental problems. In the 0-6 age group problems included the following: gross motor, 1,269; fine motor, 1,142; speech, hearing, language, 886; social and emotional maladjustment (not getting along with peers, siblings, parents, day care, or in the community), 1,757. Problems encountered in the 6-21 year age group

included: gross motor, 1,170; fine motor, 1,411; speech, hearing, language, 583; and social and emotional maladjustment, 2,892.

At this writing there is no information of followup (treatment or referral) of cases in Pennsylvania. Pediatricians have had difficulty with referral to child psychiatrists and mental health centers.

In summary, although developmental screening has begun with medicaid children, all children should be studied for high risk and high vulnerability at birth. Simple and clear treatment plans reflecting current knowledge could be given to include the parent and child prior to leaving the hospital. Hopefully planned periodic followup and integration into available medical and educational programs will aim toward maximum competence of each child. If children are our most valuable asset, they require number one priority.

REFERENCES

1. Office of Mental Health. Goals and Recommendations of the Task Force of the Mental Health of Children and Youth. Harrisburg, Pennsylvania, 1973.
2. Trotter, S. Massive screening set for nation's poorest children. APA Monitor, Washington, D.C., 6:9-10, 1975.
3. Kron, R. Personal communication, 1974.
4. Aleksandrowicz, D.; and Aleksandrowicz, M. Personal communication, 1974.
5. Brazelton, T. B.; and Tronick, E. Clinical uses of the Brazelton Neonatal Behavioral Assessment. Exceptional Infant, B. Z. Fuedlander, G. M. Sterritt, G. E. Kirk, eds., Vol. 3, New York: Brunner/Mazel, 1975.
6. Freud, A. Normality and Pathology in Childhood Assessment and Development. New York: International Universities Press, 1965.
7. Freud, A., et al. Studies in Child Psychoanalysis: Pure and Applied. New Haven: Yale University Press, 1975.
8. Frankenburg, W. K.; and Norht, A. F., Jr. A Guide to Screening for the EPSDT under Medicaid. U. S. HEW in cooperation with the American Academy of Pediatrics, 1974.
9. Stennis, W.; Houlihan, R.; and Green, P. Bucks County Diagnostic Grouping with Strategies for Teaching. Bucks County Public Schools, Doylestown, Pennsylvania, 1970.
10. Stennis, W. Diagnostic Education Grouping in New Mexico. The New Mexico Department of Hospitals and Institutions, 1972.
11. Colarusso, C. A. 1972-73 Final Report, Bucks County Diagnostic Educational Grouping with Strategies for Teaching Program. Bucks County Public Schools, Doylestown, Pennsylvania, 1973.

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Volunteer faculty in affiliate teaching hospitals

PAUL J. POINSARD, M.D.

ANGELO P. ANGELIDES, M.D.

RUDOLPH C. CAMISHION, M.D.

JOHN J. DeTUERK, M.D.

THEODORE J. BERRY, M.D.

JOHN J. McKEOWN, JR., M.D.

Philadelphia

The Volunteer Faculty Association of Jefferson Medical College and Thomas Jefferson University Hospital is dedicated to defining and enhancing the invaluable contributions of volunteer and part-time faculty and staff. The rich heritage of Jefferson as a world famous medical college and hospital until recent years has been almost exclusively a creation of volunteer faculty and staff. It is part of the dedication of the Volunteer Faculty Association to keep this heritage alive and perpetuating.

The following are excerpts from a panel discussion presented by senior clinicians and teachers at a general meeting of the Volunteer Faculty Association of Jefferson Medical College on December 16, 1975. The topic of discussion was "The Volunteer Faculty in the Affiliate Teaching Hospitals."

Role of the volunteer

John J. DeTuerk

"Among the volunteer group I would like to mention a group of people that are frequently not thought of—the members of the Board of Trustees. They are active and directly involved in the day-to-day running of the present day community hospital. Though the actual administrator is a full time paid employee, he is directly under the control of the Board of Trustees, and trustee members, all volunteers, meet regularly with volunteer physicians on the several important hospital committees. In the past years physician-trustee committees have been almost unheard of. Thus it is not only the physicians, but a large group of non-physicians who are giving volunteer services to all of the community hospitals on a regular daily, weekly, and monthly basis.

"Most community hospitals function with a preponderance of volunteer physicians, particularly the clinical

departments of medicine, surgery, and obstetrics and gynecology, not supplied with offices, secretaries, or any hidden benefits. These physicians volunteer their services in many facets: caring for the indigent patients, the outpatient clinics, as well as regular monthly meetings. Volunteer service thus includes professional, administrative, and teaching obligations."

Need for volunteers

Angelo P. Angelides

"A full time, salaried faculty member usually is an individual who is overwhelmed with the administrative duties of his department. As medi-

cine has progressed into highly technical tertiary care areas, full time supervision of these units is required. The patient ratio for these individuals is very small when compared with physicians in practice either in or outside the hospital environment. They are restricted as teachers because of the narrow expertise range so that the student is unable to see an individual as a total patient. The individual seeing a patient as a total person is a better educator for the neophyte student than the full time tertiary care individual.

"The need for the teacher of the patient as a whole person is great and there is no way that the average medical school can afford a full time, fully salaried faculty."

Volunteer of Bryn Mawr Hospital Theodore J. Berry

"I remembered something that I heard from the platform at the Congress of Medical Education in Chicago when someone questioned whether we needed medical schools. Medical students receive most of their basic training at the university level and most of their clinical training in community hospitals. Why do we need medical schools?

"In the early days of medical education, community hospital was almost a dirty word. The family physician was someone who had made his mistakes and finally had sent the patient into the academic world for the truth. The community hospital has changed. Physicians who are attending and teaching have changed. The university needs the community hospital.

"Among the teachers in the volunteer faculty we must include the resident staff. I fully believe at least half of the training of students at the community hospitals is gained from exposure to the resident staff.

"The affiliate hospital volunteer

Dr. Poinsard, now immediate past president of the Volunteer Faculty Association of Jefferson Medical College, is professor of psychiatry and director of postgraduate education in psychiatry for Jefferson. He is chairman of the Committee on Public Information of the Philadelphia Psychoanalytic Society, and a past president of Pennsylvania Psychiatric Society, Philadelphia Psychiatric Society, the Medical Club of Philadelphia, and the Jefferson Alumni Association. Dr. Angelides is clinical associate professor of medicine at Jefferson and vice president for affairs at Cooper Medical Center. Dr. Berry is director of medical education at Bryn Mawr Hospital. Dr. Camishion is professor of surgery at Jefferson and president of the medical staff of Cooper Medical Center. Dr. DeTuerk is clinical professor of surgery at Jefferson and chairman of the medical staff of Methodist Hospital. Dr. McKeown is associate professor of surgery at Jefferson and attending surgeon at the Mercy Catholic Medical Center.

faculty members are interested in being involved in the educational activity. The budget for our educational program is nearly a million dollars a year. In our hospital we have approximately 100 regularly scheduled conferences a month, which is a lot for a hospital with mostly private patients in a community with which most of you are familiar, where the patients are quite different from those seen in the city. The students are involved with many of the teaching conferences often in the form of journal clubs or round table discussions or grand rounds. We accept the fact that the stand up lecture is fast becoming obsolete as a teaching form. The students don't want to sit and listen to somebody talk about something that they want to talk about. They like to be involved with patient care; this can happen and does happen in the community hospital."

Full time v. volunteer Rudolph C. Camishion

"In a relatively short professional life, I have seen a fascinating evolution in medical education. My personal academic career has progressed from a status of salaried full time to geographic full time to volunteer. Academia would undoubtedly consider this as a deteriorating career. My own personal assessment is that I have made advancing strides towards emancipation.

"I watched a system that provided top grade medical education, where the chairman of the department derived his income primarily from private practice and received a small stipend from the medical school for his academic pursuits, to a situation where the chairman of the department is primarily salaried and has very little contact with clinical practice. This seems somewhat anomalous since the primary responsibility of the chairman of a clinical department is the organization and the teaching of the practice of medicine. Is it possible for medical students and house staff to relate in a positive way to a physician-teacher who does not demonstrate his clinical acumen and medical expertise on live patients? Is he considered by these people in training to be an adequate role model? Can he be seen, as was true

before, as the most knowledgeable and best physician in the region and for this reason he functions as chairman?

"After World War II, two things happened. First, there occurred a tremendous explosion of knowledge in basic science which was then applied to clinical medicine. Second, the government began expending huge sums of money through the National Institutes of Health (NIH) for research. The triumverate aims of the university hospital—teaching, patient care, and research—shifted to research, teaching, and patient care. With large grants available, particularly for research, academicians in many instances were able to generate their own salaries from outside sources. The medical school, in turn, was then able to financially support a large full time faculty. At the same time, members of the volunteer faculty, who were not research oriented, became second-class citizens in academic circles, and yet were primarily responsible for most bedside teaching. The tumor eventually began to outgrow its own blood supply. Large numbers of full time faculty members dependent upon NIH funds were stranded when the source of their salaries was gradually withdrawn. The medical schools were then left with research oriented physicians who are more or less now a financial burden on the medical school. The medical school, in order to support these individuals, has had to turn around and say, 'practice medicine.'

"Within the past five or six years, the pendulum has been shifting back towards the center and, not surprisingly, the old time geographic full time system is becoming the vogue in university hospitals. This system, in my mind, represents a reasonable compromise. The clinical faculty members practice medicine and receive a stipend for their administrative and teaching duties. There is interest in teaching, there is interest in patient care, but there is still an interest in research. All three factors now seem to be coming into balance. The one factor common to the evolving systems has been the existence, vitality, and interest of the volunteer faculty. It has been and will be, *the sine quo*

non of clinical medical education."

Mutual dependence John J. McKeown

"When I was in medical school in the department of surgery every one of the students in the class went through Jefferson Hospital, and took their surgical clerkships at Jefferson Hospital. One could, on occasion, take an elective elsewhere, after rotation with the entire class through Jefferson Hospital.

"Since that time 70 percent of the department of surgery's teaching is being done by affiliate hospitals; I am sure that this is probably true in the other departments.

"Should there be a mutual dependence of the university and the affiliate hospital? By all manner and means. If 70 percent of the teaching is being done by the affiliate hospitals, then the university is heavily dependent on the affiliate hospitals. However, the Jefferson faculty, in my opinion, has not been utilized to the extent that it could be to reinforce the teaching programs at the affiliate hospitals.

"There is a real need for the chairman of each department to personally visit the affiliate hospitals at least once a year to inspect the facilities and review the teaching programs being carried on by them, in order to personally document the

"In addition, there is an interesting aspect of mutual dependence of affiliated hospitals with parent institutions which has not been explored in depth. That is the opportunity for coordinated clinical research with the large number of clinical opportunities available by pooling of patients.

"There has been a mutually satisfactory rotation of surgical residents from Jefferson through the departments of surgery of many of the affiliate hospitals where the residents are more likely to be exposed to the more commonly performed surgical procedures seen in a community hospital. In those affiliated hospitals which have their own approved residency programs, a further strengthening and improvement of these programs could be obtained by rotating affiliate hospital residents through selected divisions of the parent university." □



Gerald H. Escovitz, M.D., Villanova, was recently appointed associate dean of the Medical College of Pennsylvania's newly created office of medical education. The new education office is a result of a seven year grant of \$6.5 million from the Veterans Administration. Dr. Escovitz is former associate dean for continuing education and extramural affairs for the medical college.



DR. ESCOVITZ



DR. POPKY

George L. Popky, M.D., East Falls, professor of radiology for the Medical College of Pennsylvania, was recently named chairman of the department. He has been on the faculty since 1968 when he joined as assistant professor of radiology.

The American Cancer Society has awarded \$214,099 in research grants to the University of Pittsburgh and four faculty members. **Paul A. Chervenick, M.D.**, professor of medicine, received \$44,100 for his study on "Kinetics and Control of Hematopoietic Stem Cells and Neutrophilic Granulocytes." **Bernard Fisher, M.D.**, director of oncology for the University Health Center of Pittsburgh and the school of medicine, was granted \$38,125 for his ongoing program, "Primary Breast Cancer Therapy Cooperative Trials." **James H. McMaster, M.D.**, associate professor of orthopedic surgery, received \$36,874 for studying "Osteogenic Sarcoma Cell Phasing: *In Vivo* and *In Vitro*," and **Patricia A. Hoffee, Ph.D.**, associate professor of microbiology, received \$95,000 to study "Effects of Carbohydrates on Transformation of Liver Cells."

James B. Donaldson, M.D., professor of medicine at Temple University School of Medicine, was recently named senior consultant for the new Diagnostic Medical Center at Temple University Hospital. He is immediate past president of the Philadelphia County Medical Society.

Frederick J. Samaha, M.D., recently became professor of neurology and pediatrics at the University Health Center of Pittsburgh. He is acting chairman of the department of neurology at the University of Pittsburgh School of Medicine and director of the muscular dystrophy clinics at Presbyterian-University and Children's Hospitals.

William E. Staas, Jr., M.D., was appointed recently as associate medical director of Magee Memorial Rehabilitation Center, Philadelphia. He is clinical professor of rehabilitation medicine at Jefferson Medical College, Thomas Jefferson University.

Two Temple University Hospital staff members, **Mordecai M. Popovtzer, M.D.**, and **Stephen Berney, M.D.**, have received a grant from the Delaware Valley Lupus Foundation to study how hemodialysis affects the kidneys of patients with lupus erythematosus. Dr. Popovtzer is chief of the nephrology section, and Dr. Berney is director of the arthritis outpatient clinic at Temple.

Ferne M. Georges Moore, M.D., was recently appointed deputy commissioner in the Philadelphia Department of Public Health. She has been associated with the department since 1956 and has served as a clinician with the Child Health Conference Program and as a public health physician with the Community Health Services. In 1970 Dr. Moore was named project director of the model cities' family medicine program of the U. S. Department of Housing and Urban Development. From 1970-74 she was director of Temple University's Comprehensive Group Health Services Center.

She has been assistant professor of community medicine at Temple's school of medicine and on the faculty of the department of community health at Hahnemann Medical College and Hospital.

Jose A. Gelpi, M.D., and **George A. Lapes, M.D.**, were recently certified by the American Board of Psychiatry and Neurology. Both are on the medical staff of York Hospital.

Alfred Ayella, M.D., Merion, was appointed recently as chairman of the division of surgery at West Park Hospital. He is a senior surgeon at St. Agnes Hospital and clinical associate professor at Hahnemann Medical College and Hospital.

S. Kendrick Eshelman, III, M.D., Lancaster, and **Mark W. Shulkin, M.D.**, Bala Cynwyd, were recently named fellows of the American Psychiatric Association.

Norman R. Klinman, M.D., Philadelphia, a professor for the University of Pennsylvania, recently received the Parke-Davis Award of the American Society for Experimental Pathology. He was awarded for his contributions to the whole spectrum of immunology.

Thomas S. Davis, M.D., was recently named assistant professor of surgery at the Milton S. Hershey Medical Center. He has been associated with Hershey since 1974 and during the past year has been chief resident and instructor in plastic surgery.

J. Thomas Millington, M.D., upon his recent retirement, received citations and honors in recognition of over 30 years in the public health field. Most recently, he was a regional health commissioner for the State Department of Health. He received the Pennsylvania Meritorious Service Medal, a certificate of appreciation from the State Department of Military

Affairs, citations from the State Senate and the Department of Health, and a letter of appreciation from Governor Milton J. Shapp.

Harry E. Bacon, M.D., emeritus professor of surgery at Temple University School of Medicine, was recently awarded an honorary degree by the University of Nuevo Leon in Monterrey, Mexico. Additionally he has been appointed visiting professor at the University of Guadalajara. Dr. Bacon is director general of the International Society of University Colon and Rectal Surgeons.

Charles P. Carson, M.D., Drexel Hill, was named chairman of the department of laboratories of Albert Einstein Medical Center, Daroff Division. Since 1962 Dr. Carson has been chairman of the department of pathology at Sacred Heart General Hospital, Chester.

Two physicians have been appointed assistant professors of surgery at the Pennsylvania State University College of Medicine at Hershey. **Edward H. Williams, Jr., M.D.**, was named assistant professor in the division of cardiothoracic surgery, and **Thomas S. Davis, M.D.**, was appointed assistant professor in the division of plastic surgery. Dr. Williams is a former instructor in surgery and research associate in physiology. Dr. Davis is former chief resident and instructor in plastic surgery at Hershey.

The Milton S. Hershey Medical Center, The Pennsylvania State University, has added three physicians to the teaching staff: **V. Patrick Mahataphongse, M.D.**, as assistant professor of surgery in the division of plastic and reconstructive surgery; **Charles B. Grossman, M.D.**, as assistant professor in the department of radiology; and **William Berman, Jr., M.D.**, as assistant professor of pediatrics.

Gregory Klimock, M.D., was recently appointed clinical instructor in pathology at the University of Pittsburgh School of Medicine. He has been a pathologist for the Grove City Hospital since 1975.

The American Association of Clinical Urologists recently installed **Russell B. Roth, M.D.**, as president during the group's annual convention. He is past president of the American Medical Association and the Erie County Medical Society, past chairman of the Board of Trustees and past speaker of the House of Delegates for the State Society, and past speaker of the House of the AMA. He is attending urologist at the Saint Vincent Health Center, where he has practiced since 1946.

David J. Hoffman, Jr., M.D., was certified recently in internal medicine. He has been associated with the York Hospital since 1975.

Philip Henstell, M.D., Forest City, was recently named Physician of the Year by the Governor's Committee on Employment of the Handicapped. Governor Milton J. Shapp presented the award during a luncheon held in Hershey in honor of Dr. Henstell.

He was chosen as Physician of the Year because of his special concern for the handicapped throughout his more than 40 years of medical practice.

A graduate of Jefferson Medical College, Dr. Henstell has practiced medicine in Forest City since 1935 and has served as physician for the local child health clinic since 1947. In addition to his work with the handicapped, personal contributions to the area include service to the Susquehanna County Selective Service office, the Carbondale and Forest City Red Cross bloodmobiles, and the Carbondale Primary Health Care Center.

Santo Longo, M.D., was appointed recently as codirector of the pathology department of the J. C. Blair Memorial Hospital. He has previously been associated with Geisinger Medical Center, Danville, the American Oncologic Hospital and Pennsylvania Hospital, Philadelphia. Until joining Blair, he was an associate in pathology at the Hospital of the University of Pennsylvania.

Alvin F. Goldfarb, M.D., Bryn Mawr, was recently named medical coordinator of ambulatory gynecologic

services at Pennsylvania Hospital. Additionally, he has been named clinical professor of OB/GYN for the University of Pennsylvania School of Medicine.

Sidney H. Schnoll, M.D., Ph.D., was named assistant medical director and clinical director of Eagleville Hospital and Rehabilitation Center. He is assistant professor of psychiatry at the University of Pennsylvania School of Medicine and has been medical director of HELP, Inc., a Philadelphia drug treatment agency, since 1969.

Susan V. McLeer, M.D., Germantown, was appointed recently as assistant dean for medical education at the Medical College of Pennsylvania. The office of medical education works with the faculty in developing mechanisms for the provision of clearer statements of educational objectives and development of more precise and useful techniques for ongoing evaluation of the curriculum.

S. Thomas Westerman, M.D., was recently appointed clinical assistant professor of otorhinolaryngology at Hahnemann Medical College and Hospital. He has served as chairman of the section of ear, nose, and throat of the Medical Society of New Jersey, and has been a staff member at Riverview Hospital, Redbank, and Monmouth Medical Center, Long Beach, New Jersey.

Stephen L. Curry, M.D., recently became assistant professor of obstetrics and gynecology for the Pennsylvania State University College of Medicine, Hershey. Until joining Hershey, he was a fellow in gynecological oncology at the M. D. Anderson Tumor Institute, University of Texas Medical Center. In 1973 he received the American College of Obstetrics and Gynecology President's Award for outstanding research in OB/GYN.

Robert C. Aber, M.D., was recently appointed assistant professor of medicine for the Pennsylvania State University College of Medicine, Hershey. A native of Easton, Dr. Aber has most recently been a fellow in infectious diseases at Massachusetts General Hospital, Boston.



David E. Kuhl, M.D., Rosemont, recently received the Society of Nuclear Medicine's Pioneer Citation for "an outstanding career as a research scientist and educator." Dr. Kuhl introduced photorecording in the field of radioisotope scanning and later designed and built the first cross section scanner. He was the first to make transmission computed tomographs of patients. Dr. Kuhl is presently chairman of the department of radiology at the Hospital of the University of Pennsylvania and professor of radiology at the university.

Sheldon Baum, M.D., York, was recently appointed associate professor of radiology and head of nuclear medicine at The Milton S. Hershey Medical Center. Dr. Baum, editor in chief of *Clinical Nuclear Medicine*, is the author of two textbooks, *A Systematic Atlas of Nuclear Medicine Imaging*, soon to be published, and *Basic Nuclear Medicine*.

Edwards P. Schwentker, M.D., was recently named assistant professor of surgery, division of orthopedic surgery, The Pennsylvania State University College of Medicine, Hershey. He is former associate surgeon at the Alfred I. du Pont Institute and staff surgeon at the VA Hospital, Wilmington, Delaware. He has served as associate professor of health sciences at the University of Delaware, and director of the Muscular Dystrophy Association clinic at the du Pont Institute.

Milton Alter, M.D., was named recently as professor and chairman of the department of neurology at the Temple University School of Medicine. He has served as chief of neurology for the Veterans Hospital in Minneapolis and professor of neurology at the University of Minnesota.

Paul S. Friedman, M.D., Philadelphia, was recently elected a fellow of

the newly created American College of Nuclear Medicine. Dr. Friedman is a fellow of the American College of Radiology, American College of Chest Physicians, and the American College of Legal Medicine.

Richard J. Hildebrandt, M.D., was recently appointed director of the department of obstetrics and gynecology at Polyclinic Hospital, Harrisburg. He is former acting director of the division of maternal and fetal medicine and former associate professor of OB/GYN for the Milton S. Hershey Medical Center, Hershey.

Richard B. Tenser, M.D., and **Isam H. Shehadeh, M.D.**, recently joined the faculty of the Pennsylvania State University College of Medicine at Hershey. Dr. Tenser is serving as assistant professor of medicine and microbiology and Dr. Shehadeh is assistant professor of medicine.

Jon D. Shoop, M.D., recently became chairman of the division of radiology at the Geisinger Medical Center, Danville. He is former associate professor of radiology and pharmacy at the University of New Mexico, where he was instrumental in organizing the department of nuclear medicine.

The National Institutes of Health recently awarded a Research Career Development Award to **E. Michael Van Buskirk, M.D.** Dr. Van Buskirk is an assistant professor of surgery in the division of ophthalmology at the Pennsylvania State University College of Medicine at Hershey.

A. R. Lavender, M.D., Scranton, was appointed recently as director of the Moses Taylor Hospital Hemodialysis Unit. He is director of medical education at Moses Taylor and former director of the Moses Taylor Kidney and Hypertension Institute.

James L. Curtis, M.D., Danville, was

recently re-elected a director of the Better Vision Institute during the group's annual meeting. The institute is an educational organization whose membership includes ophthalmologists, optometrists, opticians, optical supply houses and manufacturers, and educational institutions.

A portrait of **Edwin O. Geckeler, M.D.**, professor emeritus of surgery, Hahnemann Medical College and Hospital, was recently hung in the college library in honor of his many years at the college. The portrait was painted by **Hobart Reimann, M.D.**, professor of medicine at Hahnemann. Dr. Geckeler graduated from Hahnemann in 1922, joined the faculty in 1924, and later became professor of orthopedic surgery.

Jean Gowing, M.D., was recently awarded a commemorative plaque by Memorial Hospital, Philadelphia, in honor of 50 years of service to the hospital. Emeritus professor of pediatrics in the Medical College of Pennsylvania, she serves the pediatric clinics of Memorial Hospital and the medical college.

Elliot S. Vesell, M.D., was recently named a member of the scientific advisory committee of the Pharmaceutical Manufacturers Association Foundation, Inc. Dr. Vesell is professor and chairman of pharmacology and professor of medicine at the Pennsylvania State University College of Medicine, Hershey.

Aureliano Rivas-Flores, Jr., M.D., Pottstown, was recently decorated for completing 34 years of active service with the U.S. Army and Army Reserves. A brigadier general in the Army Reserves, he received the decoration, the first Oak Leaf Cluster to the Legion of Merit, during a ceremony at Fort Hamilton, New York, headquarters of the 8th Medical Brigade, commanded by General Rivas since 1971.

Dr. Kelly promises active administration

William J. Kelly, M.D., of Pittsburgh, was installed as president of the State Society September 17. On the day before, while still president elect, he delivered this message and call to action to the House of Delegates.



Dr. Kelly, flanked by Vice President John V. Blady, M.D., and President David S. Masland, M.D., is introduced by Speaker of the House John B. Lovette, M.D.

I am extremely proud and privileged to be standing here this afternoon. I thank all of you for it. When I accepted the office of Vice President a few years ago I made two promises to you. First, to either grow hair or wear a wig. You can see I haven't done either one of them. Second, to quit smoking cigars. I can assure you I've kept that promise several times and now I'm back again.

I've titled this "The State In The Union" for many reasons. I've been hanging around PMS for twenty years and watching things and people come and go. In the past two years I've been preparing myself for the year ahead and I've observed some interesting happenings. The *state* is that the Board and officers have been spending too much time in the insurance business and the fact is we haven't been acting like the Union we should be by being more aggressively together in our decisions. I hope the Board of the captive insurance company will take this burden and handle it appropriately for the benefit of our members who need it. I want all of you to know I don't expect to spend this coming year wallowing in the insurance business. Our Society should be developing the true picture of what we are—practicing physicians who care how people are treated—who care what the government and related health agencies are forcing upon us—and who are concerned about the health, conduct and education of *all* of the Doctors in Pennsylvania—not just the ones who belong to our Society.

We have a large membership. I am recommending to this House an objective market research survey of the PMS membership and the physician non-membership in this state. Doctors are intelligent, concerned people who inherently are unionized together in their practices, offices, staff appointments, social and professional associations, and in many other ways which all of you understand. I want this House to order the Board of Trustees to conduct this survey of what medicine in this state wants and needs, and to send in the questions you want answered on this survey. I'd like to work on something *for us* for a change instead of being forced to work on something for other people in order to stay out of trouble. Let's be offensive and aggressive, not defensive and oppressive. If we can establish this baseline we can build. I'd like to build up not out.

And while we are on membership, I'd like to ask the House to take a hard look at restructuring our Councils and Committees. To me some are duplications (i.e., Committee on Objectives and Long-Range Planning). I think the Board of Trustees and the House, as a union, should be going in the same direction. I personally feel at times the Board does too much and then every year, after the fact, forces things on the House for approval. I think this House should initiate the action and have the Board account to it at the end of the year. I have heard some people mention that we should have more meetings of the House of Delegates through the year. I don't want more meetings to go to, but if you want them and we need them to survive in a better climate then let's have them, and I'll be there. As an aside, I might mention that frankly, I do think the Board makes too many unilateral decisions that affect our individual practices, and then we have to argue about them at our next House of Delegates meeting. I therefore recommend re-establishment of the Committee to Study Councils, Commissions and Committees to give us a clearer perspective.

I thought maybe this year we could keep Blue Shield out of our discussions, but after seeing what's going on, talking to many physicians, and listening to Blue Shield representatives, I'm convinced that we must improve our position in Blue Shield. In my opinion, Blue Shield is no longer a charitable enterprise. Blue Shield takes care of those who can afford it, or whose unions can afford to pay for it. It is now another insurance company, not a Doctor's Plan. It could eventually become another bureaucracy running government insurance plans exclusively. Is this O.K. with us? As your president, I want to know your attitude toward Blue Shield and what changes you support relative to Blue Shield.

You know, there's something old hat that I'd like to bring up—that's membership in our Society in the near future. This House should give some serious thought to losing members. I ask these questions: Are we prepared to lose members, charge those who stay more, and then go about the state representing fewer doctors? There are several ways this can come about—to mention a few—unified membership in AMA, continuing medical education requirements, captive insurance company



George A. Rowland, M.D., chairman of the Board of Trustees, installs Dr. Kelly president of the State Society.

assessment, dues increase and, at this late date, adoption of Resolutions 3 and 16. I am of the impression that our constituent county societies are trying to maintain or increase their membership. Some of the things we may be doing in this House may be directly against their wishes. I would remind you that the AMA lost 35,000 members with a dues increase, but raised the dues so much that they were able to turn things around financially, and now consider themselves successful. I ask you—does money speak louder than colleagues? I'm concerned how you decide this as I strongly feel there's power in numbers. I'm requesting our eloquent speaker to refer this matter to a reference committee for serious consideration.

Just a word about medical schools, as independent as they are. I appreciate their role in the production of quality care physicians. I know they are sincerely interested in putting out good doctors—and they do. But they are not putting out enough of them—the reasons being money, space, faculty, etc. We could be their helpful allies if they would just take a few more of the quality students that live in Pennsylvania and not be so restrictive in their admission policies. If there were closer liaison between them and us, perhaps we could support them more in their desires, legislative and financial. We're not too proud to do this as you know.

What about this health care crisis we've been talking about in Pennsylvania the past two years? Where are we, the PMS, in it? I think personally we are a little bit further than we were two years ago, thanks to Dr. Crane and Dr. Masland and this House. I caution you however, we need to step up our efforts in this regard. Again I say to you: some way, somehow, this Society has to be the persuasive to get our medical schools to admit and graduate Penn-

sylvania citizens who have motivation, home town roots, reasonable grades, and financial wherewithal to do the job—not candidates from other states who come here to train and then go back home to practice. This doesn't make sense. I say if this Society can't convince the schools to do this then we go to the Legislature and pass laws to make them do it. No one can convince me that money and faculty are holding them back. I think the medical schools should make extra effort, on the part of faculty, put in a little extra time, alter their two-hundred year old admission policies, and make a few personal sacrifices for the honor of medicine, like the rest of us do. It's time their philosophy be changed around. It is the practicing physician who has been the captive audience and supplier for medical schools in the past. If it takes a bill introduced into the Legislature, then let's get working on one and introduce it this year. I recommend that this House charge the appropriate Council with this responsibility and not sit on our hands in this area for another year. Dr. Masland said in his speech a year ago and I quote "When we go to the Legislature, it should be for priority items." *This is a priority item.*

This reminds me of an area of interest that has become increasingly important to this Society in the past few years—governmental relations. I am hereby recommending to this House that the PMS develop a Search Committee to seek out and have PMS hire with the House's consent a *paid physician lobbyist*. Someone who can get to the legislators and also educate the members. We need a physician to express the moral, practical, and medical viewpoint to the Legislature as someone who has practiced in the arena and is respected for his profession of medicine. Our present very capable lay lobbyists can show him how to do it and whom to contact but let the direct answers to questions come from the mouth of a physician. It may be that PaMPAC would consider helping to defray the expense of such a person. Personally, I think we ought to hire him and pay him.

I also feel our relationship with the secretary of health should be improved. His sitting in on part of our Board of Trustees meetings is *not enough*. Recently he doesn't even do that. This past year it's pretty clear that the health department has been instrumental in alienating nursing homes where we care for our patients and also in influencing HSA Areas as well as our county societies. A representative physician, not a staff man, should meet with him frequently, eyeball to eyeball, on both medical and political issues, and remind him that he, too, is an M.D., and really one of us.

We ought to be firmly establishing both the obligation and right of physicians to look at the governmental invasion into the medical care of patients. How is this done? Certainly with the expertise this organization has we can question, debate, and even threaten suit on some of the regulations that come across our desks as edicts of how we must practice and care for our patients. Our problem is that we just accept the edict or refuse to see those kinds of patients. I think we should be aggressive and challenge them in the future. Perhaps we should take time and just study the legality of some of these so-called orders we are receiving. You well know that everybody is

suings these days. Again in the area of relations, not necessarily governmental, we should find a way to offer staff service to specialty societies without having them pay for it in toto. We can offer basic services, not necessarily all of them. We should take time and look into the cost accounting on this issue and have both parties share the expense. It is necessary for a strong society to have the support of all the specialties.

Next, I would like to touch on a very sensitive area in our organization—the staff. I'll be accused of shaking the house of cards on this, but I feel I have to say it. "Our PMS staff is too great." I mean that. They are so proficient that the physicians around sometimes don't have time to initiate or formulate the policy, just read it and argue with it. In my opinion, there is not enough supervision of the staff by responsible physicians. Somehow, we ought to have an in-house committee do this. You say the Executive Committee of the Board. The Executive Committee of the Board has had meetings the president elect hasn't been invited to. There is laxity in our organization in looking over staff's shoulder. I feel the physician should initiate the advice and contents of all our so-called "white papers," and let the staff put it into proper paper order and perspective. Staff could get us involved in areas, not directly concerned with patient care and results. Speaking of staff and relation to the Executive Committee, I feel there should be many more phone conferences, including all members of the Board so that our input can be adequately expressed before the decision is made, not just the Executive Committee. I recommend that copies of any correspondence or actions by the Executive Committee be transmitted immediately to all Board members by mail so that all of us and all of you through your elected trustees will be well informed and speak with authority in handling questions and problems at the district level. Maybe the vice president should take on the duty and it will help prepare him more for the Presidency. In recent years, some vice presidents just went to a few meetings and didn't do very much. I am one of them. I feel our staff could stand a little more physician contact and supervision by the elected officers.

I don't want decisions and statements falling back on the lay staff so that when we get them they have no medical flavor. I think most doctors, if they can't taste something, don't want to swallow it.

There are projects going on in this Society that need your support. Allow me to name a few:

First: *The Medical Cooperative*—just try it, the savings and goods will be unusually acceptable to you. Needless to say, I recommend adoption of Resolutions 6, 11 and 18.

Second: *PaMPAC*—You know what this is. They need the money. We need the support. It just has to help us do better for medicine.

Third: *The PMS Auxiliary*—I just can't believe all they've done for medicine in Pennsylvania. If I didn't see it in writing I'd have a hard time believing the enormity of their activity. They are silent workers. Help them when and where you can.

Fourth: *Continuing Medical Education*—assist your colleagues in getting their required hours and put some effort and suggestion into the *modus operandi* of this

project to take care of the old and retired physician with many years of active membership and loyalty to the medical profession. Maybe a new category of membership should be considered.

Fifth: *The Sick Physician*—report your colleague to the appropriate authority so he can get well and back into the main stream of medicine. This should be a major project for the coming year.

I know some of you are wondering about my council and committee appointments for the forthcoming year. Considerable time was spent on selection, taking into consideration such items as recommendations from county societies and trustees, meeting attendance, and geographical distribution. I can assure you that there have been many new appointments—about 50 percent in all, but at the same time there are reappointments of those members who form a basic nucleus of a committee by reason of their long term service to this Society or a particular committee. I hope you will all accept this philosophy and continue to serve and support this society to the best of your ability.

Before closing I want to thank the ACMS for putting the yoke on my back. Many presidents of PMS have come from Allegheny County, and I'm proud to be in that distinguished company.

I accept the honor and challenge you have given me and promise this House I will keep my eye on everything I can. I feel that with God's help we can all succeed in making the Pennsylvania Medical Society one to be dealt with in the future plans of medical care for the citizens of this great Commonwealth.

This Society, like this nation, has a rich natural foundation and background. Let us all continue to develop it for the future. □



Society's activities in review at Annual Session



David S. Masland, M.D., of Carlisle, immediate past president of the Society, presented the following review of activities during his term of office which ended September 18, during the meeting of the House of Delegates.

Delegates. At the left he is shown receiving the past president's medal from George A. Rowland, M.D., chairman of the Board of Trustees.

As I prepared this report, a flood of memories from this Bicentennial year crossed my mind. They ran all the way from pantosomatitis and the governor's chiropractic solution to black lung disease to swine flu and the "Pennsylvania Incident."

Unquestionably, the malpractice insurance crisis continued to occupy most of our time. In the early part of the year we worked closely with Paul Abrams, the director of arbitration panels, in fleshing out the details of the arbitration system under Act 111 of 1975. Mr. Abrams asked for physicians willing to serve on the panels. I am pleased to report to you that our call for volunteers was promptly and vigorously acted upon. By February 18 we were able to provide Mr. Abrams with a list of nearly 2,400 physicians by county and specialty ready and willing to serve on arbitration panels.

The legal profession has also responded, and federal jury lists have supplied the names of potential lay members. Altogether more than 10,000 volunteers have returned their questionnaires which have been filed by county. As of the end of August, nine cases had been filed, with the first case scheduled for arbitration in September or October.

Meanwhile, a joint Senate-House Committee was meeting almost weekly to prepare corrective amendments for Act 111. This committee, mandated by Section 1006 of the law, and chaired by Insurance Commissioner William Sheppard, came to be known as the 1006 Committee. Your Society was represented at all its meetings and provided input. The result was that some very necessary amendments were signed by Governor Milton J. Shapp in July. They permit physicians to self-insure; permit the administrator of arbitration panels to "consider and approve offers of settlement for fiduciaries, minors or incompetent parties at any time prior to the first meeting of the arbitration panel; "expand arbitration panels' jurisdiction to include non-health care providers included in suits

with health care providers; and require physicians with more than 50 percent of their practices out of state to carry \$200,000/\$600,000 coverage, but exempt them from paying into the Catastrophe Loss Fund. While these amendments were necessary to make Act 111 workable, that law is still not the answer to the malpractice problem.

While our focus last year was on the Legislature, this year it has been on the insurance industry and, more specifically, Argonaut. The situation heated up again this spring when Argonaut filed for an overall 42 percent rate increase amounting to \$7.4 million—over and above the 207 percent granted last year. At hearings called by Insurance Commissioner Sheppard, we criticized the performance of the entire insurance industry. We observed the somewhat arrogant approach of Medical Protective and we called attention to the lack of innovation by the industry and the need for re-examination of such old assumptions as the risk classes and territories.

But the gut issue was and remains the 42 percent rate increase. Our independent actuary, Lewis Roberts of Woodward and Fondiller, studied the Argonaut filing and simply was unable to support a 42 percent rate hike based on Argonaut's figures. Accordingly, the Society, through its legal counsel, opposed the Argonaut rate filing. To date the Insurance Department has not rendered a decision.

I now turn to a report on our captive insurance company and our status with Argonaut.

Argonaut said consistently until this August that it wanted to terminate its agreement with the Society and Frank B. Hall and totally withdraw from the medical malpractice market in Pennsylvania.

In order to be prepared to fill the void if Argonaut were successful in breaching and terminating its contract with the Society, the Society formed Pennsylvania Medical Society Liability Insurance Company.

Since we last met on July 11, there have been negotiations with Argonaut which broke down and Argonaut has

repudiated the contract and said it will *not* abide by the terms of the contract.

Argonaut sued the Society in Federal Court seeking a decision that contract is null and void and seeking damages in excess of \$25 million.

Argonaut also said it would non-renew 438 physicians.

The Society sued Argonaut to enjoin it from breaching the contract, and to compel it to insure physicians presently insured and new applicants.

There has been a lot of legal maneuvering and there are presently four law suits pending.

In the last two and one-half weeks there have been extensive and serious settlement negotiations which would have involved Pennsylvania Medical Society Liability Insurance Company (captive) succeeding to Argonaut under the contract so there would be no disruption to physicians insured under our sponsored program.

The Board of Trustees of the Society and the Board of Directors of the company have both decided that our captive company can not and will not compete with Argonaut.

Our captive can only get off to a healthy start with Argonaut's book of business.

If Argonaut wants to get out of the market, we will take over from Argonaut, *not* before.

Settlement negotiations have broken down. I cannot tell you what will or even is likely to occur.

However, this Society needs authority to raise money to capitalize the captive when and if the necessity occurs.

Accordingly, the Board of Trustees has submitted to the House Supplemental Report B which levies a uniform assessment in the amount of \$500 on all members and an additional selective assessment in the amount of \$500 to those actually applying for insurance. Final implementation is subject to approval by the Board of Trustees. I recommend with all the enthusiasm and sincerity that I can muster that the House of Delegates adopt the resolution in Supplemental Report B.

When I spoke to you in the special session of the House of Delegates, I stressed the fact that the captive insurance company was a framework into which we hope to fit some of the pieces in our search for a solution to the malpractice problem. The captive, therefore, is a vehicle which, if successful, will benefit all members of the Society. I particularly feel that this is true for the Medical Protective policyholders. There is no question where the Insurance Department stands on this issue. They lobbied heavily for a mandatory exclusive Joint Underwriting Association. The realization of that goal would be well within the reach of the department should Argonaut leave. The number of class three, four, and five physicians orphaned by Argonaut would be sufficiently large to trigger the exclusive JUA. Under a JUA, there is no incentive to do anything but calculate rates. I believe it is in the best interests of all of us to fund and launch the PMS captive rather than subjugate ourselves to the whims of the insurance industry—the true owners and operators of the Joint Underwriting Association.

It has been said that patients who bear a portion of the insurance risk, through co-insurance or deductibles, tend to use their health benefits more wisely. If all of us have a

stake in the captive company it demonstrates our good faith and willingness to shoulder our share of the problem and work meaningfully towards loss prevention. Frequently, we have deplored the meddling of outsiders in the profession of medicine. It would now appear that we are being offered the opportunity to row with our own oar. I, for one, welcome the challenge.

During this same year we have seen across the country the first ripple of countersuits by physicians. We all recall the successful countersuit by the Skokie, Illinois, radiologist, Dr. Leonard Berlin. But do you know that coincidental to his winning that suit there was a sudden drop in medical malpractice suits filed in the Chicago area?

On the question of countersuits in Pennsylvania, I think the legal profession should understand that the Society, through this House of Delegates, has pledged to use the full financial resources of the Society to support worthy countersuits. We have, through our publications and presidential letters, asked every member of the Society to let us know of potential countersuits. Legal counsel has now reviewed your many suggestions and reports to me that within a matter of weeks they will be ready to file our first countersuits.

Malpractice suits against lawyers have jumped 50 percent in the last five years. Liability insurance rates for lawyers have increased 100 to 300 percent in each of the past two years. In fact, famed attorney Melvin Belli and his partners were recently successfully sued for legal malpractice and held liable for \$200,000 in damages. Now we all know that the insurance rates for lawyers are still nominal—in the hundreds of dollars. But perhaps it's like the story of the farmer, his mule and the two by four. First you have to get its attention.

I had hoped to be able to report to you that our pilot project in voluntary binding arbitration had started. And such would have been the case had the insurance industry been cooperative. Unfortunately, the pilot hospital ran into a roadblock with its insurer. We now are in the process of setting up the pilot again, this time with a hospital insured by the captive insurance company of the Hospital Association of Pennsylvania. I consider this project a priority and urge that it be pursued vigorously.

I have been talking about the actions of the Society in the malpractice arena. There is also another side of the coin—those actions which our members can and must take.

One of these which plays an important and positive role is the continuing education requirement. At this Annual Session we pass an important landmark. In a few weeks the line must be drawn to suspend those few who do not qualify for membership in 1977. It is gratifying to see that more than 93 percent of our members have met the continuing education requirement. I am certain that by the time the final reports are in we will find that only a handful have failed to comply. One cannot argue the principle of continuing education, only the ways to accomplish it.

I believe continuing education is an important factor in the malpractice equation. We now have data from the National Association of Insurance Commissioners which point to misdiagnosis as the most frequent cause of mal-

practice suits. Misdiagnosis also adds to the cost of medical care by improperly using expensive facilities and services. If continuing education can improve our skills at diagnosis even by a few percentage points, we will have saved our patients millions of dollars.

In the official call you will find suggested amendments to the Bylaws which define the term "expert witness." This definition, if adopted, would permit action against any member who testified as an expert witness but failed to meet our definition. Such a physician would open himself to a charge of unethical conduct and be subject to disciplinary action. This is necessary to implement Resolution 75-22. I believe this is an important step we should take and along with the Committee on Constitution and Bylaws, I urge you to adopt this amendment.

Despite the many malpractice problems, there were other important activities this year. Commonwealth Court handed down a tie decision in our suit against the Health Department on the regulation of physicians' office laboratories. We have appealed to the state Supreme Court. We again had to take legal action in our attempt to block implementation of Blue Shield's eye care program which equates optometrists with ophthalmologists. We finally succeeded in getting the legislature to permit attachment of anatomical donor cards to drivers' licenses. A beefed-up child abuse law was passed, and the statewide hotline installed. In both the latter instances we acknowledge the strong interest and activity of the PMS Auxiliary. The Pennsylvania Medical Cooperative became more than an idea and proved its original premise—namely, that it can save members thousands of dollars a year.

The Pennsylvania Medical Care Foundation received nationwide recognition by having its PSRO Support Center contract renewed for another 15 months. Our Workmen's Compensation insurance program paid a dividend to subscribers for the third year in a row. Twenty-seven thousand dollars was the total return this year to those members who buy their workmen's compensation insurance through the Society endorsed program. Incidentally, in my own group of four physicians, this dividend from PMS workmen's compensation equalled approximately 50 percent of our dues to PMS.

But of all these activities one event stands out in my mind as having perhaps more lasting significance than many of the others. After being postponed for a year because of the malpractice crisis, the Board finally held its long-range planning session. For two days the Trustees and council chairmen met in task forces and asked, "What's the Pennsylvania Medical Society all about, and where should it be going?" Here are some highlights from that meeting.

First there was agreement about the ascendancy of the specialty societies and their potential for the dilution of power through splintering. In the political arena the size and cohesiveness of a group are vital ingredients for success. I would therefore urge the specialty delegates to come forward with suggestions on how the Society may strengthen its relationships with the specialty societies. We now have a department of specialty services. There ought to be ways that PMS can provide some services to specialties. Specialties should also explore what services

they might purchase from the Society. Certainly in the area of lobbying we must both walk the extra mile and work together. Nothing is so convenient to a legislator as when he can point to warring factions within a group and tell them to get their house in order before they talk to him. The Society has built a skilled lobbying team over the years and established itself as the credible voice of medicine in Pennsylvania. I want to enhance this asset, not destroy it. Nor do I believe it is cost effective for each specialty to have its own lobbying operation. Let us discipline the diversity of our special interests and exploit the strength of our numbers.

Another term which surfaced frequently is negotiation. One spin-off of this is a plan to hold a negotiating seminar for key officers and staff of the Society. It is my hope that this initial effort will be successful and will be the forerunner of numerous negotiation seminars which eventually will be open to all specialty, county society, and hospital medical staff officers. It may soon be time for us to ask every member of the Society to sign a contract designating PMS as his official bargaining agent with third parties such as the Department of Welfare and its medicaid program.

I do not have time here to go into detail, but I am confident that in the months ahead we will begin to see the seeds of the planning meeting bear fruit. I am confident that the Board will hold similar planning meetings in the future.

Finally, you will recall when I addressed you in Lancaster last fall, I held in my hand copies of the *Federal Register* which daily spews out regulations from the federal bureaucracy. Well, here is a sequel to that story.

The *Washington Star*, the other daily newspaper in Washington, D.C., runs a column every day called "Gobbledygook." That's the word used to describe the gibberish that appears in most federal publications, especially rules and regulations. Government workers are encouraged to send in examples of "Gobbledygook" which if used earn \$10. Well, here is an example of "Gobbledygook" from the National Transportation Safety Board, dealing with aircraft, which the *Star* published on July 27 and which I couldn't resist.

"The Inertial Navigation System uses deviation to generate corrective commands to drive the system from a position where it is to a position where it isn't, arriving at a position where it wasn't, it now is.

Consequently, the position where it is now is the position where it wasn't, and it follows the position where it was is the position where it isn't."

I suppose it's writing like that, and probably worse, that caused HEW Secretary Mathews to order that his department consult broad segments of the public before it publishes controversial regulations. Accordingly, "HEW will notify the public through town hall type meetings, advertisements, news releases, professional and service organizations, mailings, the *Federal Register*, and HEW's ten regional offices" of its intent to propose regulations. Normally we will have 45 days to comment on the intent to write regulations. The point of raising this issue is that I believe that we should insist on the same rules here in

Pennsylvania, for the amount of gobbledygook spewed out by the state regulations is no less impressive than that from the Washington scene.

Finally, at the very bottom of this announcement by Secretary Mathews is the statement that HEW also plans training sessions for its writers so that regulations are written in "clear, concise English."

To the extent that we have succeeded in accomplishing the objectives which you set for us last year, I refer you to scores of members who gave of their time and talent to Society work this year. This is a copy of the PMS directory. It appeared in the January issue of the "Journal." It lists those who served this year on our various councils, commissions, and committees. In any accounting of the Society's assets, these physicians are to be valued more highly than land or buildings or equipment. At this time, I formally thank each one of them. To the extent that we failed to achieve our objectives I personally take the responsibility. I can only tell you that I made an honest and sincere effort. However, I would be less than candid if I did not tell you that at times the job was a pain in the neck.

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As you go back to your communities, there is one message I ask you to take with you. It stems from my concern and yours over the unjust criticism of medicine in the press. That criticism must not go unchallenged.

I believe that we are the victims of our own success. All too often we have succumbed to the occupational disease of hero-worship. Through our many clinical successes, and television medical dramas, we have allowed ourselves to be flattered into assuming the responsibility for the total health of 212 million Americans. Health care has turned into the 27th amendment. This makes for colorful rhetoric, but is absolutely undeliverable. Let's tell it as it is:

There is no way that an individual can turn over the total responsibility for his health to insurance companies, hospitals, doctors, nurses, and the government. If he becomes sick . . . then he can expect to have his sickness treated. But keeping healthy is primarily his job. Neither you nor I can force a cigarette into his mouth, make him exercise, force him to lose weight, or improve his living conditions.

Somewhere we got off on the wrong foot talking about "health" insurance. There is no such thing. There is, and we have, in fact, "sickness" insurance, which starts paying out money as soon as the individual starts using the health care system. And in 99 percent of the time that's when he has lost his health and is sick. An HMO presented as it is by Senator Kennedy and others as a method of maintaining health rather than a method of overcoming illness is a perpetration of this health insurance hoax.

As long as we physicians allow ourselves to be flattered into accepting the responsibility for keeping Americans healthy, we perpetuate the impossible dream and hasten the day of socialized medicine.

The vast amount of sickness in this country today is far more responsive and related to the patient's life style than to the prescriptions and treatments of doctors. We should not allow ourselves to be the scapegoat for an expensive health care system. The expense of the system is largely inherent because of its goal (restoration of health) and the complicated, time-consuming, inefficient technologies which must be used.

Make no mistake, the way to cut health care costs in this country is not to put more regulations on doctors and hospitals, but to cut down on the number of sick people.

I hold out absolutely no prospect that we shall make any significant progress in this area, short of perhaps another total Arab oil blockade, but I do believe we can stop apologizing for what we do and what it costs. We have allowed the politicians to shift the burden of proof to us, a ploy at which they are masters. What the public has to understand is that our hospitals are filled today with people brought there largely by their own acts or inconvenience. Overeating, overdrinking, smoking, lack of exercise, speeding, drunken driving, motorcycle riding, psychosomatic ills, and the host of elective procedures available to improve the quality of life, these account for the majority of patient volume. The negligence committed by all of us against our own health far exceeds any negligence committed by physicians. Let the public understand what the real problem is before they create a problem bigger than the one they started out to solve. □

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Proceedings

127th Annual Session

of the

House of Delegates

Philadelphia, September 16-18, 1976

(Secretary's Note: Favorable action by the House of Delegates on reference committee recommendations can be assured unless noted otherwise.)

Opening Session of the House, October 16, 1976

Dr. John B. Lovette, Speaker of the House, called the opening session of the House of Delegates to order at 1:15 p.m., Thursday, September 16, 1976, in the Grand Ballroom of the Bellevue-Stratford Hotel, Philadelphia. The Speaker then acknowledged a patriotic Bicentennial musical tribute played by the Old City Fife and Drum Corps of Philadelphia and a Bicentennial slide show prepared by the American Medical Association. After receiving a report from the Chairman of the Committee on Credentials indicating that a quorum was present, the Speaker called upon Robert Poole, III, M.D., Chester County, former chairman of the Committee on Medicine and Religion, to offer the invocation. Following the invocation, the Speaker indicated that delegates should be aware of Resolution 72-6 prohibiting smoking in the House of Delegates or reference committee hearings. The Speaker also requested that anyone presenting amendments to resolutions and motions prepare a written copy and deliver it to the rostrum.

COMMITTEE ON RULES

Gabriel M. Lizak, M.D., Schuylkill County, Chairman of the Committee on Rules, presented the following written report:

"Mr. Speaker and members of the House of Delegates:

The reference Committee on Rules met and unanimously approved the adoption of the Standing Rules of the House of Delegates of the Pennsylvania Medical Society as published on pages 7-8 of the 1976 *Official Reports Book*.

Mr. Speaker, I recommend that the Standing Rules of the House of Delegates be adopted as presented."

NECROLOGY REPORT

The House stood in tribute following the Necrology Report presented by George A. Rowland, M.D., Chairman of the Board of Trustees:

"At this time, it is customary to ask you to give a moment's thought to our members who may have been with us here a year ago but, in the past months, have responded to their last roll call. Their names have been memorialized in county medical society bulletins and in PENNSYLVANIA MEDICINE, the journal of the Pennsylvania

Medical Society

"From September 1, 1975 to August 31, 1976, we have lost by death 187 members: 10 not over 50 years of age; 82 between 51 and 70; and 95 in the group ages 71 to over 90. Of these 187 members, 101 were Associates, all of whom were 70 years of age or over. The Necrology Report at the last Annual Session reported the loss of 155 members.

"May we rise for this moment in silence and respect to those members who have passed to their eternal reward during the past year."

REPORT PENNSYLVANIA MEDICAL POLITICAL ACTION COMMITTEE

Charles K. Zug, III, M.D., Lehigh County, chairman of the PaMPAC Board of Directors, presented an informational report to the House. Dr. Zug's report is included as Appendix A to these proceedings.

REPORT PENNSYLVANIA MEDICAL COOPERATIVE

Robert N. Moyers, M.D., Crawford County, vice president of the Pennsylvania Medical Cooperative, presented a status report on the Co-op. This report is attached as Appendix B.

INTRODUCTIONS

D. Ernest Witt, M.D., Columbia County, vice speaker of the House of Delegates, introduced officers of the Society, members of the Judicial Council, and members of the Board of Trustees and Councilors.

APPROVAL OF PROCEEDINGS

The Proceedings of the 126th Annual Meeting of the Society held in Lancaster, October 6-8, 1975 and found on pages 47-94 in the December 1975 issue of PENNSYLVANIA MEDICINE were approved. The proceedings of the Special Session held in Camp Hill, July 11, 1976 and found on pages 52-54 in the September, 1976 issue of PENNSYLVANIA MEDICINE were approved.

ADDRESS OF THE PRESIDENT

David S. Masland, M.D., Cumberland County, president, presented a report on the many areas in which the Society has been active during his tenure as president. The ad-

dress, which was referred to the Reference Committee on Reports of Officers, appears elsewhere in this issue.

REPORT OF THE AMA DELEGATION

As required by the resolved portion of Resolution 71-1: AMA Delegation Report on Plans, the House received a brief report from Malcolm W. Miller, M.D., Philadelphia, chairman of the PMS Delegation:

"Mr. Speaker, Members of the House of Delegates:

"I call your attention to the complete report of the Pennsylvania Delegation to the American Medical Association which appears on pages 79 to 83 of the *Official Reports Book*. My remarks today will be confined to those items which I believe should be emphasized.

"The Pennsylvania Medical Society was represented by a full complement of delegates at the Clinical Meeting of the AMA in Honolulu, Hawaii, in December of 1975; and at the Annual Meeting in Dallas, Texas, in June of 1976. Your delegation continues to remain active and energetic in the organizational affairs of the AMA.

"At the June meeting, Dr. William Y. Rial, of Swarthmore, was re-elected vice speaker of the AMA House of Delegates and Dr. James B. Snow of Philadelphia was elected to the newly created Council on Scientific Affairs.

"As noted in our report, seven resolutions were introduced at the Clinical Session and three were introduced at the Annual Session. Action taken on these resolutions is outlined in our report.

"As you know, many key issues were discussed during the Honolulu and Dallas meetings. These will be reviewed during our Open Hearing scheduled for tomorrow—Friday—at 9:00 a.m. in the rear of this room. Everyone is welcome and I personally urge you to attend to let us have the benefit of your opinions."

PENNSYLVANIA DELEGATION OPEN HEARING

It was announced that the Pennsylvania Delegation to the AMA would hold an open hearing Friday morning, September 17, at 9:00 a.m., in the Grand Ballroom with the Pennsylvania Delegation sitting as a special committee. The purpose of the hearing was to afford the members an opportunity to ask questions of the delegation and also for the delegation to receive information on the members' views of the AMA.

PRESENTATION OF BENJAMIN RUSH HOUSE GAVEL

During the past year the Society has solicited funds for the restoration of the Benjamin Rush House, which is located in Philadelphia. Dr. Daniel Blain, vice chairman of the Benjamin Rush House Committee, presented a gavel made of the original timbers of the House to President Masland in recognition of the Society's contribution of \$11,531.

DISTINGUISHED GUESTS

The following distinguished guests were presented to the House: Arthur P. Keefe, M.D., president, Medical and Chirurgical Faculty of Maryland; John S. Madara, M.D., president, Medical Society of New Jersey; Lad F. Grapski, chairman, Hospital Association of Pennsylvania; Vernon

V. Bass, M.D., president elect, Michigan State Medical Society; John J. Mahood, M.D., president elect, West Virginia State Medical Association; Jacqueline Fehling, speaker of the house, Pennsylvania Society, American Association of Medical Assistants.

ADDRESS OF THE PRESIDENT ELECT

William J. Kelly, M.D., Allegheny County, president elect, presented a report on his plans for the upcoming year entitled "The State in the Union." With the exception of that section concerning Pennsylvania medical school admission criteria, which was referred to the Reference Committee on Governmental Relations, Dr. Kelly's address was referred to the Reference Committee on Reports of Officers. Specific recommendations include: an objective market research survey of the PMS membership and other physicians in Pa; re-establishment of the Committee to Study Councils, Commissions, and Committees; growth in Society membership vs. increased costs of membership; paid physician lobbyist; rapid and complete dissemination of information pertaining to correspondence or actions by the Executive Committee. The text of Dr. Kelly's address appears elsewhere in this issue.

ACCEPTANCE OF REPORTS AND RESOLUTIONS

The material contained in the 1976 *Official Reports Book* was presented for acceptance to the House.

ANNOUNCEMENT

PENNSYLVANIA MEDICAL CARE FOUNDATION

The following announcement was made by the Speaker with regard to the Pennsylvania Medical Care Foundation: "As you know, according to the bylaws of the medical care foundation, the members of the Pennsylvania Medical Society House of Delegates are also the administrative members of the Pennsylvania Medical Care Foundation. In the packet you will find the 1976 annual report of the Board of Directors of the Pennsylvania Medical Care Foundation. It has been referred to the Reference Committee on Medical Service B. It is the recommendation of the Speaker that the House determine to hold the annual meeting of the Pennsylvania Medical Care Foundation tomorrow afternoon. We recommend that immediately after concluding the report of the Reference Committee on Constitution and Bylaws, the House consider the Reference Committee report on Medical Service 'B'. At the conclusion of Medical Service 'B', we believe the House should recess and immediately convene the meeting of the administrative members of the Foundation. Following the annual meeting of the Foundation, we would reconvene the House of Delegates and continue with nominations and elections."

ADDRESS OF THE PRESIDENT

PENNSYLVANIA MEDICAL CARE FOUNDATION

The Speaker called upon Sidney O. Krasnoff, M.D., Philadelphia County, president of the Pennsylvania Medical Care Foundation, for a few remarks concerning the annual report of the Foundation. Dr. Krasnoff specifically addressed problems inherent with the collection of medi-

cal data. His remarks were referred to the Reference Committee on Medical Service "B" and appear as Appendix C of these proceedings.

SUPPLEMENTAL REPORTS

The following supplemental report was contained in the *Official Reports Book*: Supplemental Report A, Committee on Medical Benevolence (Referred to Reference Committee on Professional Relations and Services, see Appendix D).

The following supplemental reports were contained in the delegates' packet: 1. Supplemental Report B, Report of the Board of Trustees and Councilors, pertaining to captive insurance company assessment (Referred to Reference Committee on Medical Service A, see Appendix E); 2. Supplemental Report C, Report of the Board of Trustees and Councilors on August 11 Board meeting (Referred to Reference Committee on Reports of Officers, see Appendix F); 3. Supplemental Report D, Report of the Council on Governmental Relations (Referred to Reference Committee on Governmental Relations, see Appendix G); 4. Supplemental Report E, Report of the Committee to Study Physicians' Unions (Referred to Reference Committee on Reports of Officers, see Appendix H); 5. Supplemental Report F, Report of the Board of Trustees and Councilors, update of Annual Report (Referred to Reference Committee on Reports of Officers, see Appendix I); 6. Supplemental Report G, Report of the Council on Medical Service (Referred to Reference Committee on Medical Service A, see Appendix J); 7. Supplemental Report H, Report of the Council on Education and Science (Referred to Reference Committee on Education and Science, see Appendix K). All of the above supplemental reports were received as the business of the House.

FINANCE COMMITTEE REPORT

Leroy A. Gehris, M.D., Berks County, chairman of the Finance Committee, presented the following report of the Finance Committee of the Board of Trustees and Councilors which was referred to the Reference Committee on Reports of Officers:

"Mr. Speaker, Members of the House of Delegates:

"A copy of the proposed budget for 1977 as approved by the Board of Trustees has been distributed for your information. It also contains the comparative figures of the budget approved for 1976, as well as the actual expenditures for the period January 1 through August 31, 1976, which shows a surplus of \$150,445. For this year to date, we have realized a total of \$60,016 in reimbursement from the Federal Government for administrative services in connection with the Regional Medical Program. For 1976, the Board authorized funds totaling \$150,000 to cover the cost of resolving the malpractice issue. As of August 31, \$71,505 of these funds has been spent. If the balance were to be used up this could considerably affect the surplus and this could happen as litigation costs mount. However, we anticipate ending the year 1976 in good financial position.

"The 1977 budget as approved by the Board anticipates a deficit of \$107,423 and is based on the current annual

assessment of \$150 per full dues paying member. This budget was carefully reviewed by the Finance Committee upon two separate occasions before it was submitted to the Board. A few minor changes were made, but both the committee and the Board felt that the requests of the various councils, committees, and departments are reasonable and represent the monetary needs to carry out their mandated programs. You will note that one thing is missing—the reimbursement from the Federal Government for administrative costs for the Susquehanna Valley Regional Medical Program. This program will be phased out as of September 30, 1976 and represents the greater portion of the deficit. Great care in operating the Society's office and carrying out its programs have been exercised in the past and we urgently request the continued cooperation of all units of the Society in this respect.

"A few comments are in order with regard to several resolutions which will be considered by this House of Delegates.

"**Resolution 76-3** dealing with the forgiveness of dues for those physicians entering their first year of practice following completion of training, if adopted, would result in revenue losses of approximately \$40,000 annually (*Secretary's Note: Resolution not adopted*).

"**Resolutions 76-6, 76-11, and 76-18** all relate to financial and staff support for the Pennsylvania Medical Cooperative. If favorable action is taken on these resolutions, it is impossible to predict what the related costs would be until the Board of Trustees has an opportunity to study what the extent of the Society's support should be, if any (*Secretary's Note: Substitute Resolution adopted*).

"**Resolution 76-8** requests a feasibility study to determine whether a union legally constructed offers any solution to the current problems facing medicine. If an outside consulting firm is retained to perform the service, the cost would range between \$10,000 and \$15,000 (*Secretary's Note: Resolution not adopted*).

"**Resolution 76-16** recommends a 50 percent reduction in dues for physicians for the first year in practice and could result in an annual revenue loss of some \$20,000 (*Secretary's Note: Resolution adopted*).

"**Resolution 76-19** recommends that the Society initiate a study to determine the desirability and feasibility of a merger of Pennsylvania's Blue Cross plans and Pennsylvania Blue Shield. Such a study could cost the Society \$15,000 plus (*Secretary's Note: Resolution referred to Council on Medical Service*).

"**Resolution 76-20** pertains to the discontinuance of reimbursement to teaching anesthesiologists by Pennsylvania Blue Shield for their full fee if part of the services to a patient have been physically performed by an intern or resident under the supervision of an anesthesiologist and recommends that the Society oppose such action. The resolution recommends that if legal action is brought by an individual or organization to enjoin such action on the part of Blue Shield the Society should participate in such suit by filing amicus curiae briefs. Possible costs would be \$5,000 (*Secretary's Note: Resolution amended and adopted*).

"In addition, it should be noted that no funds have been budgeted for 1977 with regard to the malpractice situation. Regretably, we expect this problem will still be with us next year in some form. The 1976 budget included \$150,000 and it is likely that these costs could be as much or more in 1977. On the other hand, circumstances may develop which will preclude the necessity of the Society spending any further money on this problem at all in 1977. The cost center for such expenditures may shift to the newly created insurance company.

"A recommendation for the dues for 1977 will be made at the last session of the House after all the actions taken by you are recorded and their financial impact measured.

"If there are any questions regarding the budget for 1977 or the financial condition of the Society, I recommend that you attend the hearing of the Reference Committee on Reports of Officers where members of the Finance Committee and others will be available to answer questions and hear your opinions."

RESOLUTIONS

The following resolutions were received less than thirty days before the meeting of the House of Delegates and were accepted as the business of the House:

Resolution No. 76-19

(Referred to Reference Committee on Medical Service A)

Subject: Pennsylvania Blue Cross and Blue Shield Merger, Feasibility Study

Introduced by: Domenick A. Cruciani, M.D., President and Delegate, on behalf of the Lackawanna County Medical Society

Author: Joseph N. Demko, M.D.

Resolution No. 76-20

(Referred to Reference Committee on Medical Service A)

Subject: Payments to Physicians in Teaching Setting by Medicare Fiscal Intermediary

Introduced by: Herbert C. Dodge, M.D., Anesthesiology
Author: Herbert C. Dodge, M.D. (Anesthesiology) and Executive Committee of the Pennsylvania Society of Anesthesiologists

Resolution No. 76-21

(Referred to Reference Committee on Governmental Relations)

Subject: Mental Health Procedures Act 143

Introduced by: Rex A. Pittenger, M.D., Allegheny County
Author: Rex A. Pittenger, M.D.

Resolution No. 76-22

(Referred to the Reference Committee on Medical Service A)

Subject: Medicaid Reimbursement

Introduced by: Harold E. Swensen, M.D., Secretary, on

behalf of the Allegheny County Medical Society

Author: Matthew Marshall, Jr., M.D.

Resolution No. 76-23

(Referred to the Reference Committee on Professional Relations and Services)

Subject: Emeritus Membership Category

Introduced by: Harold E. Swensen, M.D., Secretary, on behalf of the Allegheny County Medical Society

Author: Ralph J. Stalter, M.D.

Resolution No. 76-24

(Referred to the Reference Committee on Medical Service B)

Subject: Pennsylvania Responsibility for JCAH Functions

Introduced by: Harold E. Swensen, M.D., Secretary, on behalf of the Allegheny County Medical Society

Author: Matthew Marshall, Jr., M.D.

Resolution No. 76-25

(Referred to the Reference Committee on Medical Service A)

Subject: Blue Shield

Introduced by: Milton M. Perloff, M.D., on behalf of the Philadelphia County Medical Society

Author: Milton M. Perloff, M.D.

Resolution No. 76-26

(Referred to Reference Committee on Medical Service A)

Subject: Audit of Government Programs

Introduced by: Milton M. Perloff, M.D., on behalf of the Philadelphia County Medical Society

Author: Milton M. Perloff, M.D.

Resolution No. 76-27

(Referred to Reference Committee on Medical Service B)

Subject: PSRO Data Management

Introduced by: John L. Steigerwalt, M.D., Delegate, Montgomery County Medical Society

Authored by: John L. Steigerwalt, M.D., Delegate, Montgomery County Medical Society

Resolution No. 76-28

(Referred to Reference Committee on Medical Service A)

Subject: Definition of Stillborn, Act 66 of the General Assembly of 1953 (The Vital Statistics Act)

Introduced by: David P. Morrison, Jr., M.D., Secretary on behalf of the Bucks County Medical Society

Author: David P. Morrison, Jr., M.D.

REFERENCE COMMITTEES

Reference Committees for the 1976 Annual Session of the House of Delegates are listed below:

Constitution and Bylaws

- *Betty L. Cottle (Blair) Chairman
- *Frederick G. Brown (Montour)
- *Edward N. Moser (Lycoming)
- *John P. Whiteley (York)
- *Charles A. Heisterkamp (Lancaster)
- Joseph B. Blood (Bradford) Alternate

Credentials

- David A. Smith (Dauphin) Chairman
- James L. Harrison (Lycoming)
- Anita J. Herbert (McKean)
- Sidney A. Parsons (Delaware)
- Harold E. Brown (Montour)
- O. K. Stephenson (Perry) Alternate

Education and Science

- *Theodore A. Tristan (Dauphin) Chairman
- *David L. Miller (Clairon)
- *George A. Tushim (Clinton)
- *Roderick R. McLeod (Armstrong)
- *Norman L. Eckberg (Montour)

Governmental Relations

- *Robert N. Moyers (Crawford) Chairman
- *Rex A. Pittenger (Allegheny)
- *Robert Poole, III (Chester)
- *Milton M. Perloff (Philadelphia)
- *R. Howard Griffen (Venango)

Medical Service A

- *R. William Alexander (Berks) Chairman
- *Robert J. Carroll (Allegheny)
- *Frank J. Tornetta (Montgomery)
- *Edward J. Resnick (Philadelphia)
- *Gerald L. Andriole (Luzerne)

Medical Service B

- *Charles K. Zug, III (Northampton) Chairman
- *Donald C. Brown (Westmoreland)
- *Dominick A. Cruciani (Lackawanna)
- *John Helwig, Jr. (Philadelphia)
- *J. Scott Hommer (Blair)
- Thomas E. Patrick (Columbia) Alternate

Professional Relations and Services

- *Joseph N. Demko (Lackawanna) Chairman
- *Stanley P. Mayers (Centre)
- *Donald E. Parlee (Bucks)
- *Wayne W. Helmick (Beaver)
- *Loraine H. Erhard (Clearfield)
- Robert A. Schein (Allegheny) Alternate

Reports of Officers

- *Conrad A. Etzel (Delaware) Chairman
- *Joseph F. Alcaro (Adams)

- *Herbert C. Perlman (Cumberland)
- *William A. Shaver (Lebanon)
- *Robert B. Stuart (Erie)
- Sidney O. Krasnoff (Philadelphia) Alternate

Rules

- *Gabriel M. Lizak (Schuylkill) Chairman
- *James R. Dorenberg (Allegheny)
- *Henry H. Fetterman (Lehigh)
- *John L. Steigerwalt (Montgomery)

Tellers

- Gilbert M. Hoffman (Northampton) Chairman
- Samuel G. Woodings (Mercer)
- John D. Lane (Bucks)
- James R. Regan (Northampton)
- Matthew Cappuccio (Philadelphia)
- George Baker (Franklin) Alternate

**Indicates those members who signed the report.*

Alternates to reference committees—Again this year the Speaker appointed an alternate member to serve with each reference committee. The alternates were so notified and received all pertinent materials relating to their reference committee. The purpose of this procedure is to make available to the committee a substitute familiar with the business of the committee in the event that one of the regular committee members is unable to serve.

REMARKS OF PRESIDENT OF AUXILIARY

Mrs. Richard T. Smith, president, Pennsylvania Medical Society Auxiliary, addressed the House and reported on the activities of the Auxiliary including efforts in generating new members for the Pennsylvania Medical Cooperative. Her remarks were referred to the Reference Committee on Professional Relations and Services, and are available upon request. Mrs. Smith also led those in attendance in a brief period of calisthenics.

REMARKS OF PRESIDENT OF AMA AUXILIARY

Mrs. Norman J. Gardner, president of the American Medical Association Auxiliary, addressed the House. Her remarks were received for information.

COUNCILOR DISTRICT CAUCUSES

The speaker announced that councilor district caucuses would be held Friday morning beginning at 10:30 a.m. It was also noted that specialty and AMSA delegates would caucus at 9:30 a.m. on that same day. On Saturday morning, further time was reserved for additional councilor district caucuses beginning at 8:30 a.m., with the specialty and AMSA caucus beginning at 8:00 a.m. Copies of reference committee reports were made available at the caucuses.

RECESS

The House of Delegates was recessed at 3:50 p.m. until 1:00 p.m. Friday afternoon.

The Second Session of the House, September 17, 1976

The second session of the House of Delegates was called to order at 1 p.m. in the Grand Ballroom of the Bellvue-Stratford Hotel, Philadelphia. David A. Smith, M.D., Dauphin County, chairman, Committee on Credentials, reported that a quorum was present.

It was noted that Bedford, Butler, Carbon, Elk-Cameron, Huntingdon, Monroe, Perry, Potter, Susquehanna, Union, Warren, and Wyoming Counties were without representation in the House of Delegates. The speaker noted that Article VI, Section 3 of the Constitution states that: "If any component society is without any duly accredited voting member of the House of Delegates at any session thereof, then the active, senior active, intern or resident member or members registered in attendance from that component society may select himself or one delegate from their number, as the case may be, who shall be the representative of that component society and shall serve in the place of an accredited delegate."

Members of the Society who shall qualify to fill one of the vacancies were instructed to report to the Credentials Committee to apply for the vacancies.

(Secretary's Note: No one applied to fill the above mentioned vacancies.)

The following specialty societies were not represented: Colon and Rectal Surgery, Dermatology, Neurosurgery, Orthopedic Surgery, Pediatrics, Physical Medicine and Rehabilitation, Psychiatry (member present but also county delegate), Surgery, Thoracic Surgery. The following AMSA chapters were not represented: Hershey, University of Pennsylvania, University of Pittsburgh, Temple University.

REFERENCE COMMITTEE CONSTITUTION AND BYLAWS

Betty L. Cottle, M.D., (Blair) chairperson, presented the following report of the Committee:

Mr. Speaker, and members of the House of Delegates, the Reference Committee on Constitution and Bylaws has considered the material listed in the Index and presents the following report:

1. Unified Membership (pages 2 and 51-52 of the *Official Reports Book*)

At the 1975 Annual Session, Dr. Crane recommended adoption of unified membership in his address to the House. The House supported the recommendation. This policy change could not immediately go into effect until language was prepared to amend the Constitution and Bylaws. Considerable debate and polling of those present at the hearing revealed adoption of the unified membership requirement to be untimely.

Mr. Speaker, we recommend that the proposed amendments to the Bylaws not be adopted. *(Secretary's Note: Three-fourths vote required).*

(Secretary's Note: Dr. Cottle submitted an oral editorial change to this recommendation by substituting "be postponed until the 1977 Annual Session" for "not be adopted." The recommendation, as changed, reads: Mr. Speaker, we recommend that the proposed amendments to the Bylaws be postponed until the 1977 Annual Session. The recommendation of the Reference Committee, as changed, was adopted by the House of Delegates.)

2. Physician's Recognition Award: Term of Suspension (pages 2 and 52 of the *Official Reports Book*)

Discussion was heard in support of the proposed Bylaws change which reduces the term of suspension for failure to meet the continuing medical education requirements from one year till such time as the member qualifies for the physician's recognition award.

Mr. Speaker, we recommend approval of the Bylaws changes which reduce the term of suspension for failure to meet the continuing education requirement *(Secretary's Note: Three-fourths vote required).*

3. Change in Qualifications for Affiliate Membership Status (pages 2-3 and 52 of the *Official Reports Book*)

At the time the affiliate member status was developed, full time federally funded physicians were not eligible for active membership in the Society. Since that time the active member category has been opened to them as full dues paying members. Therefore, it is no longer necessary or appropriate to offer these physicians membership in the affiliate category.

The Reference Committee heard no testimony on this subject.

Mr. Speaker, we recommend approval of the deletions from the Constitution which refine the qualification for affiliate member status *(Secretary's Note: Two-thirds vote required).*

4. Clarification of Membership on Councils, Committees and Commissions (pages 3 and 53 of the *Official Reports Book*)

This clarification is recommended in order to open the Society's councils, committees and commissions to as many members as possible and to avoid overloading those members willing to devote time to the Society's administrative needs.

Mr. Speaker, we recommend adoption of the amendments to the Bylaws clarifying membership on Councils, Committees and Commissions. *(Secretary's note: Three-fourths vote required).*

5. Revised Time Limits for Special Sessions (pages 3 and 53 of the *Official Reports Book*)

Recent crises have brought to light the need to expedite future calls for special sessions.

Mr. Speaker, we recommend approval of the revised

time limits for special sessions of the House of Delegates
(Secretary's note: Two-thirds vote required).

6. Disciplinary Amendments (Pages 3 and 53 of the *Official Reports Book*)

If a component society bringing a complaint against a member of another component society is not satisfied with the disciplinary action taken, there is no clear route in the current Constitution and Bylaws whereby the case may be appealed to higher levels of the State Society's disciplinary bodies.

Mr. Speaker, we recommend approval of the addition to the bylaws which provides an appeal mechanism for any aggrieved component society (Secretary's note: Three-fourths vote required).

7. Expulsion of Unqualified Witness (pages 3 and 54 of the *Official Reports Book*)

Last year's House of Delegates adopted Resolution 75-22 as amended. This resolution was referred to this committee for preparation of language to implement it. This reference committee heard testimony unanimously and enthusiastically favoring adoption of this language.

Mr. Speaker, we recommend adoption of this amendment to the Bylaws which calls for the expulsion of an unqualified witness (Secretary's note: Three-fourths vote required).

REFERENCE COMMITTEE MEDICAL SERVICE A

Special Report

A special report of the Reference Committee on Medical Service A was presented by R. William Alexander, (Berks), chairman, as follows:

1. Supplemental Report B of the Board of Trustees and Councilors (Appendix E of Proceedings).

Mr. Speaker and members of the House of Delegates: The Reference Committee on Medical Service A has considered the 1976 Supplemental Report B of the Board of Trustees and Councilors. Considerable testimony was presented both in support and in opposition of this report. However, your reference committee is of the firm belief that the preponderance of testimony favored the adoption of Supplemental Report B with the following amendment to the first resolve:

"RESOLVED, That there is hereby levied, assessed and imposed a mandatory assessment upon all members of this Society in the amount of Five Hundred Dollars (\$500.) per each active member and a proportionate amount in accordance with the amount of dues paid for all other classification of members, payable only upon authorization of, and in accordance with, terms as to payment to be adopted by resolution of the Board of Trustees and Councilors, enforceable by termination of membership in this Society upon non-payment when due, and . . ."

Mr. Speaker, your reference committee recommends approval of the amended Resolve as contained in Supplemental Report B.

Additionally, Mr. Speaker, your reference committee recommends approval of the amendment to Chapter IX, Section 2 of the PMS Bylaws as related in Supplemental Report B.

(Secretary's Note: The House approved the resolution to amend the bylaws and the main resolution found in Supplemental Report B as amended by the reference committee, and also approved two additional amendments to the main resolution from the floor, as follows:

RESOLVED, That the authority to impose the mandatory assessment on the membership of the Pennsylvania Medical Society will expire unless this authority is reaffirmed by the House of Delegates at the 1977 Annual Meeting.

RESOLVED, That it be clear that this resolution is intended to be implemented in case the Argonaut Insurance Company does not continue its contractual responsibilities with the Pennsylvania Medical Society.).

The approved resolutions found in Supplemental Report B of the Board of Trustees and Councilors as amended, read as follows:

WHEREAS, This Society has sponsored a program of professional liability insurance underwritten by Argonaut Insurance Company (Argonaut) available to members of this Society pursuant to the terms and conditions of an agreement among Argonaut, this Society and Frank B. Hall of Pennsylvania, Inc., effective as of June 1, 1971 (the Agreement); and

WHEREAS, There are presently issues and controversy between this Society and Argonaut, some of which are pending in state and federal courts; and

WHEREAS, Argonaut has expressed a desire to terminate the aforesaid Agreement and has purportedly repudiated such Agreement; and

WHEREAS, The Society has organized Pennsylvania Medical Society Liability Insurance Company (the Company) for the purpose of succeeding to Argonaut under the Society sponsored professional liability insurance program and not to compete with Argonaut; and

WHEREAS, The Board of Trustees and Councilors has recommended that this House of Delegates authorize, levy and impose a combination of a uniform assessment of all members of this Society and an additional selective assessment to those members of this Society who apply to the Company for insurance; therefore be it

RESOLVED, That there is hereby levied, assessed and imposed a mandatory assessment upon all members of this Society in the amount of Five Hundred Dollars (\$500.) per each active member and a proportionate amount in accordance with the amount of dues paid by all other classifications of members, payable only upon authorization of, and in accordance with, terms as to payment to be adopted by resolutions of the Board of Trustees and Councilors, enforceable by termination of membership in this Society upon non-payment when due; and

RESOLVED FURTHER, That any member of this Society who terminates such membership and again applies to

become a member of this Society shall be fully liable for the assessment imposed hereby; provided, however, that the penalty of termination of membership for non-payment of this assessment may, upon recommendation of such member's Component County Medical Society and upon review and approval by the Board of Trustees and Councilors of this Society, be waived upon showing special circumstances such as, and without limitation, cessation of practice by reason of health, total removal of practice from Pennsylvania, etc.; and

RESOLVED FURTHER, That there is hereby levied, assessed and imposed an additional mandatory assessment in the amount of Five Hundred Dollars (\$500.) per member payable only upon authorization of, and in accordance with, terms as to payment to be adopted by resolution of the Board of Trustees and Councilors by members of this Society who apply to the Company for insurance; provided, however, that upon rejection of an application for insurance to the Company by a member of this Society, the selective assessment levied upon applicants for insurance shall be returned to the applicant-member; and

RESOLVED FURTHER, That appropriate officers of this Society be and they hereby are authorized to take any and all necessary and proper acts to give effect to this resolution and to contribute on behalf of this Society to the Company as policyholders' surplus any and all sums raised pursuant to the mandatory uniform and selective assessments imposed hereby; and

RESOLVED FURTHER, That it be clear that this resolution is intended to be implemented in case the Argonaut Insurance Company does not continue its contractual responsibilities with the Pennsylvania Medical Society; and

RESOLVED FURTHER, That the authority to impose the mandatory assessment on the membership of the Pennsylvania Medical Society will expire unless this authority is reaffirmed by the House of Delegates at the 1977 Annual Meeting.

In order to implement the foregoing resolution, Chapter IX, Section 1 of the Bylaws must be amended to permit an all-member assessment for use in funding the Pennsylvania Medical Society Liability Insurance Company.

Resolution to amend Bylaws

RESOLVED, That Chapter IX, Section 1 of the Bylaws of this Society be and it is hereby amended and restated in its entirety to provide as follows:

SECTION 1.-Assessments. Each Active, Senior Active, Intern and Resident Member of this Society shall, through his Component Society, pay such member's annual assessment to the Executive Vice President prior to March 1, and pay any special assessments authorized by the House of Delegates directly to the Executive Vice President prior to the due date of any special assessment. New members shall pay annual assessments in the same manner at the time of their certification or application for membership.

RESOLVED, That Chapter IX, Section 2 of the Bylaws of this Society be and it is hereby amended by striking the first sentence of such section and inserting in lieu thereof the following sentence:

A member whose annual assessment or special as-

essment is not paid at the time mentioned in Section 1 above shall be delinquent and shall not be in good standing in this Society.

(Secretary's Note: This Special Report was considered during the Second Session of the House in order to provide sufficient "lay-over time" for any additional Bylaws changes mandated by the House of Delegates. Chapter XVII of the Bylaws requires that all amendments voted on must lie over one day after being received as business of the House.)

Distinguished Guests

The following distinguished guests were introduced to the House: Joseph E. Gallagher, Esq., president, Pennsylvania Bar Association; Hymen Kanoff, D.O., president, Pennsylvania Osteopathic Medical Association; C.E. Graybeal, M.D., president elect, Medical Society of Delaware.

REFERENCE COMMITTEE MEDICAL SERVICE B

Charles K. Zug, III, M.D. (Northampton), presented the following report of the Committee:

Mr. Speaker, the Reference Committee on Medical Service B has considered all of the items listed in the Index.

1. 1976 Annual Report, Board of Directors, Pennsylvania Medical Care Foundation mailed to delegates prior to meeting. Available on request.

The Foundation's Annual Report provides a detailed account of the many activities pursued by the Foundation during the past year. The reference committee believes the Foundation has effectively carried out its stated aims and the directives of the Pennsylvania Medical Society's Board of Trustees and House of Delegates.

The reference committee considered the following recommendations contained in the Foundation's Annual Report:

A. Recommendation on page 3 regarding continued PSRO Support Center funding

The reference committee was informed that there are still four (4) PSRO areas in the state which have not been funded directly by HEW and therefore must depend on the Foundation's PSRO Support Center for technical and administrative assistance.

Mr. Speaker, your reference committee recommends the approval of the recommendation contained on page 3 of the Foundation's Annual Report advocating reaffirmation of the Society's policy regarding continued HEW funding of PSRO Support Centers.

B. Recommendation on page 5 regarding the development of local physician review organizations

The discussion of this recommendation focused on clarification of the intent. Testimony supported the concept of establishing local review organizations controlled by practicing physicians, which could elect to provide peer review services to non-governmental health insurers

and not be dependent on governmental funding.

Mr. Speaker, your reference committee recommends approval of the first recommendation contained on page 5 of the Foundation's Annual Report.

C. Recommendation on page 5 regarding medical necessity clauses in health insurance policies

There was some testimony which questioned the advisability of supporting a policy which would tend to restrict the scope of benefits included in a health insurance policy. However, it was pointed out that, in the public interest, physicians must be concerned with the cost of hospitalization and should advocate the use of health care dollars only for hospital services which are medically necessary as determined by local review organizations controlled by practicing physicians.

Mr. Speaker, your reference committee recommends approval of the second recommendation contained on page 5 of the Foundation's Annual Report.

D. Recommendation on page 7 regarding revision of Bylaws

Mr. Speaker, your reference committee recommends approval of the revisions to the Foundation's Bylaws as proposed in Appendix F of the Foundation's Annual Report.

2. Address of President, Pennsylvania Medical Care Foundation (Appendix C of these proceedings)

The reference committee believes the recommendation on page 3 of the address of the Foundation's president has merit and warrants further consideration to determine the feasibility and advisability of developing the concept.

Mr. Speaker, your reference committee recommends that the recommendation of the Foundation's president be referred to the Pennsylvania Medical Society's Board of Trustees with the request that the Board report its actions to the 1977 House of Delegates.

3. Resolution 76-27, PSRO Data Management

Subject: PSRO Data Management

Introduced by: John L. Steigerwalt, M.D.

Delegate, Montgomery County Medical Society

Authored by: John L. Steigerwalt, M.D.

Delegate, Montgomery County Medical Society

WHEREAS, Public Law 92-603 requires Professional Standards Review Organizations to collect data relevant to their functions (Sec. 1155 (a) (4) (B); and,

WHEREAS, The Pennsylvania Medical Society has expressed its judgment in favor of physician control and ownership of the data elements generated for the PSRO program; and,

WHEREAS, There are PSROs presently considering

sub-contracts with lay-controlled data processors; therefore be it,

RESOLVED, That the Pennsylvania Medical Society reaffirm its support of the need for confidentiality of PSRO data, to be accomplished only through physician ownership and control of the raw data.

(Financial Note: No financial impact.)

Requires two-thirds vote.

The testimony presented supported the basic principle of confidentiality of medical data. However, there was disagreement between the author of the resolution and those present relative to the ownership of data contained in a hospital medical record. It was pointed out that a hospital chart is the property of the hospital and the primary responsibility to control the confidentiality of this data rests with the hospital and its medical staff.

The committee agreed that the Society should continue to vigorously advocate the need for confidentiality of PSRO data as required by the PSRO law and recommends approval of the following substitute resolution:

WHEREAS, Public Law 92-603 requires Professional Standards Review Organizations to collect data relevant to their functions (Sec. 1155 (a) (4) (B); and,

WHEREAS, The Pennsylvania Medical Society has expressed its judgment in favor of physician control of the data elements generated for the PSRO program; therefore be it

RESOLVED, That the Pennsylvania Medical Society reaffirm its support of the need for confidentiality of PSRO data.

(Secretary's Note: Substitute Resolution approved as presented.)

4. Resolution 76-24, Pennsylvania Responsibility for JCAH Functions

Subject: Pennsylvania Responsibility for JCAH Functions

Introduced by: Harold E. Swensen, M.D., Secretary, on behalf of the Allegheny County Medical Society

Author: Matthew Marshall, Jr., M.D.

WHEREAS, The 1974 clinical convention of the AMA House of Delegates adopted a Pennsylvania resolution authorized by the House of Delegates which established AMA and Pennsylvania Medical Society policy that to avoid duplication, when a peer review organization, organized by the practicing physicians of the area, has determined that a medical staff has an adequate medical audit and utilization review procedure, it should be accepted by the State agency, the JCAH, Medicare, Medicaid and others unless there is evidence by the State agency or the Joint Commission that the peer review organization has not acted in the best interest of quality medical care; and

WHEREAS, This policy has been accepted by Medicare and Medicaid but not by the Joint Commission on Accreditation; and

WHEREAS, Following the rejection of that resolution by the JCAH, the 1975 Annual Convention of the American

Medical Association requested the AMA to develop with the assistance of the Joint Commission on Accreditation of Hospitals, and with the cooperation of state medical associations, the plan whereby the JCAH functions can be carried out without duplication at the state or regional level with the assurance that aspects of accreditation relating to care by physicians will be evaluated by physicians using their own voluntary formats for review; and

WHEREAS, The Board of Trustees of the AMA having had eighteen months to act upon that resolution will report to the 1976 clinical convention regarding the feasibility and possible mechanisms for implementing this resolution; and

WHEREAS, It is becoming increasingly clear that the public demands that Pennsylvania physicians be responsible for the quality and appropriateness of care rendered in their hospitals; therefore be it

RESOLVED, That the Pennsylvania Medical Care Foundation develop a plan by which the JCAH functions can be carried out without duplications and in accordance with the policies established by the Pennsylvania Medical Society and the American Medical Association; and be it further

RESOLVED, That this plan be presented to the Pennsylvania Medical Society's House of Delegates meeting in 1977 for implementation in 1978; and be it further

RESOLVED, That the Hospital Association of Pennsylvania and the Pennsylvania Department of Health be invited to participate in the development of this plan; and be it further

RESOLVED, That the assistance of the American Medical Association be utilized to the extent feasible; and be it further

RESOLVED, That the JCAH be requested to cooperate with this endeavor if it can accept AMA policy regarding medical audit and utilization review procedures as established at the 1974 clinical convention of the AMA and state and regional responsibility for JCAH functions at the 1975 annual convention.

(Financial Note: Financial impact depends upon future actions necessary.)

Requires two-thirds vote.

Testimony supported this resolution.

Mr. Speaker, your reference committee recommends approval of Resolution 76-24.

Annual Meeting Pennsylvania Medical Care Foundation

As in past years, the Annual Meeting of the Pennsylvania Medical Care Foundation was held during the 1976 House of Delegates meeting, and proceeded as follows:

"The Chair believes it wise to take a minute to be certain that all members of the House understand how we will consider the next order of business. We wish to convene the annual meeting of the administrative members of the Pennsylvania Medical Care Foundation.

"According to the Foundation's Bylaws, 'Administrative members shall consist of those persons who are duly qualified and elected delegates to the House of Delegates of the Pennsylvania Medical Society.' The Bylaws further state, 'The acceptance of election as a delegate to the House of Delegates of the Pennsylvania Medical Society by an eligible physician shall be determined to be acceptance of administrative membership in this Corporation and an intention to be bound by the Articles of Incorporation and Bylaws of this Corporation unless the delegate otherwise notifies the secretary of the Corporation prior to the annual meeting.'

"In other words, the voting members of the House are also the administrative members of the Foundation.

"At this time, the Chair will entertain a motion to recess the PMS House of Delegates and to convene the administrative members of the Pennsylvania Medical Care Foundation in the annual meeting of the Foundation.

"The Chair recognizes the President of the Pennsylvania Medical Care Foundation, Dr. Sidney O. Krasnoff. Dr. Krasnoff . . ."

"Thank you, Barney. While it's true that we are sitting now as the administrative members of the Pennsylvania Medical Care Foundation, I am sure that all of us want to expedite the business of the Foundation as quickly as possible. I believe this can best be achieved if we permit an experienced hand to guide us from the Speaker's rostrum. For that reason, I would respectfully ask the permission of the administrative members to have Dr. Lovette serve as acting Speaker of the Foundation so that he may use his skill in parliamentary matters . . . hearing no objections, Dr. Lovette, I would ask you to come back and take over."

"Thank you. Dr. Krasnoff. The principal item of business this year for the administrative members of the Foundation is the Annual Report of the Foundation, which contains several recommendations referred to the Reference Committee on Medical Service B.

"The other item of business this year for the administrative members of the Foundation is the election of five directors. The Board of Directors of the Foundation presents the following nominees for the vacancies. The Foundation's Bylaws allow for additional nominations to be made from the floor by any administrative member for all vacancies at the time of elections.

"In the event there is a contest for one of the Foundation slots, the contest will be added to the PMS ballot and delegates will cast their votes tomorrow morning.

Vacancy	Nominee	County	Term
1	Frans J. Vossenbergh, M.D.	Montgomery	3 year expires 10/79
2	Roland A. Loeb, M.D.	Lancaster	3 year expires 10/79
2	Robert B. Stuart, M.D.	Erie	3 year expires 10/79
4	Robert M. Jaeger, M.D.	Lehigh	remainder of 3 year term expires 10/77
5	Bernard B. Zamostien, M.D.	Philadelphia	3 year expires 10/79

"Are there any other nominations?"

(Secretary's Note: There were no nominations from the floor and the nominees listed above were elected.)

"The Foundation's Bylaws require that the administrative members approve all Bylaws changes. The Reference Committee on Medical Service B has considered the Bylaws changes recommended by the Foundation's Board of Directors. The Chair will now entertain a motion to approve the revisions to the Foundation's Bylaws as recommended by the Reference Committee on Medical Service B.

(Secretary's Note: The proposed Bylaws changes were indicated in Appendix F of the Foundation's Annual Report. The Bylaws changes were approved.)

"Are there any further actions or comments concerning the Foundation's Annual Report? If not, the chair will entertain a motion to file the report as presented.

"Is there any further Foundation business? If not, the chair will entertain a motion to adjourn the meeting of the Foundation and to reconvene the House of Delegates."

NOMINATIONS AND ELECTIONS

Nominations and elections were held Friday afternoon, September 17, 1976. Voting for those offices contested was held Saturday morning, September 18. The following officers were elected:

President: William J. Kelly, M.D. (Allegheny) acceded to the office of president

President Elect: John V. Blady, M.D. (Philadelphia) acceded to the office of president elect

Vice President: John B. Lovette, M.D. (Cambria)

Secretary: G. Winfield Yarnall, M.D. (Dauphin)

Speaker: D. Ernest Witt, M.D. (Columbia)

Vice Speaker: Donald E. Harrop, M.D. (Chester)

The following Trustees and Councilors were elected:

Second District: Leroy A. Gehris, M.D. (Berks)

Eighth District: David J. Keck, M.D. (Erie)

Eleventh District: William C. Ryan, M.D. (Somerset)

Two members were elected to serve on the Committee to Nominate Delegates and Alternates to the AMA. They are: John G. Hallisey, M.D., (Beaver) and David E. Morrison, M.D., (Dauphin). Both members were elected to serve full three year terms on the committee.

Charles K. Rose, M.D., (Lehigh) and William A. Limberger, M.D., (Chester) were elected to three year terms on the Judicial Council. The following district censors were elected for one year terms: Adams, **James H. Allison**; Allegheny, **William D. Stewart**; Armstrong, **Donald W. Min-
teer**; Beaver, **John G. Hallisey**; Bedford, **Philip C. Grana**; Berks, **Brian A. Wummer**; Blair, **John W. Hurst**; Bradford, **Arthur B. King**; Bucks, **Stanley F. Peters**; Butler, **Robert C. McCorry**; Cambria, **Warren F. White**; Carbon, _____; Centre, **H. Richard Ishler**; Chester, **Grant W. Bamberger**; Clarion, **Theodore R. Koenig**; Clearfield, **Fred Pease**; Clinton, **George J. Treires**; Columbia, _____; Crawford, **David D. Kirkpatrick, Jr.**; Cum-

berland, **Hans S. Roe**; Dauphin, **Robert P. Dutlinger**; Delaware, **Richard W. Garlich**; Elk-Cameron, **Robert J. Dickinson**; Erie, **Robert L. Loeb**; Fayette, **Veronica Binns**; Franklin, **Albert W. Freeman**; Greene, **David L. Avner**; Huntingdon, _____; Indiana, **Ralph F. Waldo**; Jefferson, **Nicholas F. Lorenzo**; Lackawanna, **Norman S. Berger**; Lancaster, **William G. Phippen**; Lawrence, **Gerald H. Weiner**; Lebanon, **C. Ray Bell**; Lehigh, **Frederick A. Dry**; Luzerne, **Samuel T. Buckman**; Lycoming, **Franklin G. Wade**; McKean, **Bruno P. Sicher**; Mercer, **Anderson W. Donan**; Mifflin-Juniata, **Donald E. Basom**; Monroe, **Claus G. Jordan**; Montgomery, **Rudolph K. Glocker**; Montour, **William O. Curry**; Northampton, **Walter J. Filipek**; Northumberland, **J. Mostyn Davis**; Perry, **James O. Rumbaugh, Jr.**; Philadelphia, **Charles M. Thompson**; Potter, **Francisco B. Villa**; Schuylkill, **Gabriel M. Lizak**; Somerset, **Alexander Solosko**; Susquehanna, **Michael Markarian**; Tioga, **William A. Coolidge**; Union, **Joseph Weightman**; Venango, **Kenneth H. Heasley**; Warren, **Donald J. Furman**; Washington, **John C. McGinnis**; Wayne-Pike, **Howard R. Patton**; Westmoreland, **Leslie S. Pierce**; Wyoming, **John S. Rinehimer, Jr.**; York, **Donald R. Gross**.

(Secretary's Note: The Board of Trustees has the power to appoint district censors to fill vacancies.)

REPORT OF THE COMMITTEE TO NOMINATE DELEGATES AND ALTERNATES TO THE AMA

The speaker announced the elections for delegates and alternates to the American Medical Association. The nominations of the Committee to Nominate Delegates and Alternates to the American Medical Association were published on page 1 of the *Official Reports Book*. Elected to two year terms beginning January 1, 1977, and expiring December 31, 1978, were:

R. William Alexander, M.D. (Berks)

Raymond C. Grandon, M.D. (Dauphin)

William J. Kelly, M.D. (Allegheny)

William Y. Rial, M.D. (Delaware)

George A. Rowland, M.D. (Columbia)

Five alternate delegates were elected for two year terms beginning January 1, 1977, and expiring December 31, 1978:

Donald C. Brown, M.D. (Westmoreland)

Betty L. Cottle, M.D. (Blair)

James B. Donaldson, M.D. (Philadelphia)

Michael P. Levis, M.D. (Allegheny)

R. Robert Tyson, M.D. (Philadelphia)

REFERENCE COMMITTEE PROFESSIONAL RELATIONS AND SERVICES

Joseph N. Demko, M.D., (Lackawanna) chairman, presented the following report of the committee:

Mr. Speaker, the Reference Committee on Professional Relations and Services has considered all of the items listed in the index.

1. Report of the Council on Professional Relations and Services (*Official Reports Book*, page 75)

The Council's report is very informative. It was reviewed and found to be detailed and impressive. The reference

committee would like to make special note of the ambassador recruitment program being conducted by the Council and urges that county medical societies take advantage of this campaign. The reference committee commends the Council and its staff for the work in membership recruitment and in the development of new benefits for medical society members.

The reference committee reserved discussion on that portion of the Council's report dealing with the Pennsylvania Medical Cooperative (Page 77) until later in the report.

Mr. Speaker, the reference committee recommends that the report of the Council on Professional Relations and Services be filed.

2. The reference committee has grouped the following items (*Official Reports Book*) together in a waiver of debate list.

1. Report, Advisory Committee to the PMS Auxiliary (Page 50)
2. Report, Committee on Medical Benevolence (Page 54)
3. Report, Committee on Medicine, Religion, and Bioethics (Page 55)
4. Address of the President, PMS Auxiliary
5. Report, Committee on Medical Benevolence, Supplement A (Page 82)
6. Resolution 76-7, Affiliate Membership for County Society Executives (Page 85)

Resolution 76-7

Subject: Affiliate PMS Membership for County Society Executives

Introduced by: Mark S. Reed, M.D., delegate, on behalf of the Berks County Medical Society

Author: Mark S. Reed, M.D.

WHEREAS, The medical society executives are hard working, dedicated, and contribute much toward an efficient, well organized and smooth working professional organization; and

WHEREAS, The American Medical Association has recognized their value by awarding them an Affiliate Membership in the AMA; and

WHEREAS, The Pennsylvania Medical Society should also give these executives official recognition for their contribution to organized medicine; therefore be it

RESOLVED, That the Pennsylvania Medical Society consider a change in the Constitution and Bylaws to include the county society executives as Affiliate members of the Pennsylvania Medical Society.

(Financial Note: No financial impact.)

The committee feels that the items are of a non-controversial nature. The committee commends Mrs. Smith for her outstanding year of leadership and her excellent talk to the House, Mrs. Gardner for her remarks, and the entire Auxiliary for their support throughout the years, but particularly for their efforts toward effective legislation to deal with child abuse.

Mr. Speaker, the Reference Committee on Professional

Relations and Services recommends the following: 1. File report, Advisory Committee to the PMS Auxiliary; 2. File report, Committee on Medical Benevolence; 3. File report, Committee on Medicine, Religion, and Bioethics; 4. File address of the president, PMS Auxiliary; 5. Approve report, Committee on Medical Benevolence, Supplement A; 6. Approve Resolution 76-7, Affiliate Membership for County Society Executives;

3. Pennsylvania Medical Cooperative

1. Annual Report, Pennsylvania Medical Cooperative (available on request)
2. Address of the vice president, Pennsylvania Medical Cooperative (Appendix B)
3. Resolution 76-6, Support for the Pennsylvania Medical Cooperative (*Official Reports Book*, Page 84)
4. Resolution 76-11, Support for Pennsylvania Medical Cooperative (Page 86)
5. Resolution 76-18, House of Delegates to Support Pennsylvania Medical Cooperative (Page 88)
6. Portion of Report, Board of Trustees and Councilors (Page 22)
7. Portion of Report, Council on Professional Relations and Services (Page 77)

Resolution 76-6

Subject: Support for Pennsylvania Medical Cooperative
Introduced by: Robert N. Moyers, M.D., on behalf of the Crawford County Medical Society

Author: Robert N. Moyers, M.D.

WHEREAS, The Pennsylvania Medical Cooperative was authorized by this House in 1974; and

WHEREAS, The Co-op is now in operation and its benefits are apparent to those physicians making use of it; and

WHEREAS, The use of the Co-op is a proven method of decreasing the cost of medical practice; and

WHEREAS, The economic benefits to all Pennsylvania physicians accruing from the Co-op's existence are significant and likely to become more significant; and

WHEREAS, The Co-op will be even more valuable should wage and price controls be reimposed; and

WHEREAS, The Co-op is currently suffering from undercapitalization, hindering its growth and threatening its very existence; therefore be it

RESOLVED, That the policy of this House be one of support for the Pennsylvania Medical Cooperative; and be it further

RESOLVED, That the support include necessary financial and staff support from the Pennsylvania Medical Society to maintain a viable Cooperative.

(Financial Note: Financial impact dependent upon Board action, if any.)

Resolution 76-11

Subject: Support for Pennsylvania Medical Cooperative
Introduced by: Herbert Perlman, M.D., on behalf of the Cumberland County Medical Society

Author: Herbert Perlman, M.D.

WHEREAS, The Pennsylvania Medical Cooperative was authorized by this House in 1974; and

WHEREAS, The Co-op is currently suffering from undercapitalization, hindering its growth and threatening its very existence; therefore be it

RESOLVED, That the policy of this House be one of support for the Pennsylvania Medical Cooperative; and be it further

RESOLVED, That the support include necessary financial and staff support from the Pennsylvania Medical Society to maintain a viable Cooperative.

(Financial Note: Financial impact dependent upon Board action, if any.)

Resolution 76-18

Subject: House of Delegates to Support Pennsylvania Medical Cooperative

Introduced by: John P. Whiteley, M.D., on behalf of the York County Medical Society

Author: Thaddeus Lekawa, M.D.

WHEREAS, The Pennsylvania Medical Cooperative was born from the Pennsylvania Medical Society in 1974; and

WHEREAS, The Cooperative is now in full operation and being utilized by 50 percent of its member physicians; and

WHEREAS, The Cooperative has demonstrated its ability to save the physicians' money; and

WHEREAS, The Cooperative is in a financial bind because of under-capitalization and under-utilization; therefore be it

RESOLVED, That the House of Delegates reverse its decision of non-support for the Cooperative; and be it further

RESOLVED, That the House of Delegates consider financial aid to the Cooperative. The amount of financial aid would be under the control of the Board of Trustees and Councilors for the period of time required until better utilization is made by Cooperative members and greater inventory and product lines can be offered for more varied usage by physicians.

(Financial Note: Financial impact depends on Board action, if any.)

Because of the similar nature of the items listed above, the reference committee considered them as one item.

Mr. Speaker, in view of the strong feelings expressed by the leadership of the Pennsylvania Medical Society in favor of needed support of the Pennsylvania Medical Cooperative, and in view of the very encouraging upward climb of sales figures of the Co-op and in order to protect the financial integrity of the Pennsylvania Medical Society, the reference committee submits the following substitute resolution to embody the intent of all resolutions and reports on the Co-op:

RESOLVED, That the House of Delegates reverse its decision of non-support for the Cooperative; and be it further

RESOLVED, That the House of Delegates consider financial aid to the Cooperative in the form of loans or in any other manner that will assure no financial loss to the Society. The amount of financial aid would be under the

control of the Board of Trustees and Councilors for the period of time required until better utilization is made by Cooperative members and greater inventory and product lines can be offered for more varied usage by physicians.

Mr. Speaker, the reference committee recommends adoption of the substitute resolution.

4. Membership dues

1. Resolution 76-3, Forgiveness of First Year's Dues (Page 84)

2. Resolution 76-16, Dues Reduction for New Physicians (Page 87)

Resolution 76-3

Subject: Forgiveness of First Year's Dues

Introduced by: Herbert Fellerman, M.D., Luzerne County

Author: Herbert Fellerman, M.D.

WHEREAS, The Pennsylvania Medical Society is interested in attracting new physicians into its ranks; and

WHEREAS, Doctors who are first entering practice may find it difficult to meet the initial dues payment; therefore be it

RESOLVED, That the Pennsylvania Medical Society forgive the dues of those physicians entering their first year of practice following completion of training; and be it further

RESOLVED, That the Pennsylvania Medical Society enter a similar resolution in the proceedings of the American Medical Association.

(Financial Note: Adoption of this resolution would result in an estimated annual loss in excess of \$40,000 in dues revenue.)

Resolution 76-16

Subject: Dues Reduction for New Physicians

Introduced by: Henry H. Fetterman, M.D., Lehigh County

Author: Henry H. Fetterman, M.D.

WHEREAS, Organized medicine should be making an all-out effort to represent all physicians; and

WHEREAS, The cost of local, state, and AMA dues, together with assessments, is making it increasingly more difficult for the new physician to become a part of and involve himself with organized medicine at a time when expenses are highest and income is lowest; and

WHEREAS, The older physician, who also has a lower income, has been given relief with a lesser dues structure; therefore be it

RESOLVED, That the dues for the first year of practice be at a reduced rate of 50 percent for county and state; and be it further

RESOLVED, That the Pennsylvania Medical Society introduce this resolution at the next AMA meeting for this resolution to also apply to AMA dues.

(Financial Note: Loss of at least \$20,000 per year in dues revenue.)

Because of the similar intent of the two resolutions, the Reference Committee considered them as one item.

The preponderance of comments received by the Reference Committee was in favor of Resolution 76-16 and in opposition to Resolution 76-3.

Mr. Speaker, the reference committee recommends that Resolution 76-3 not be adopted and that Resolution 76-16 be adopted.

(Secretary's Note: The Speaker divided this recommendation for separate consideration of each resolution. The recommendations of the reference committee were sustained.)

5. Resolution 76-13, Elimination of Delinquent Dues Provision (Official Reports Book, Page 87)

Subject: Elimination of Delinquent Dues Provision

Introduced by: William A. Shaver, M.D., Lebanon County

Author: William A. Shaver, M.D.

WHEREAS, Those members who become delinquent due to non-payment of dues must pay the dues for the year in which they become delinquent, as well as the current year's dues before being reinstated as members, as specified in Section 2 of Chapter IX of the Bylaws; and

WHEREAS, The House of Delegates in 1974 placed a one-year moratorium on enforcement of the delinquent dues provision to encourage those who become delinquent in the past to rejoin; and

WHEREAS, the House of Delegates in 1975 extended the moratorium another year; and

WHEREAS, The number of dues delinquent members rejoining the Society increased appreciably in the past two years; and

WHEREAS, The number of dues delinquent members rejoining the Society increased appreciably in the past two years; and

WHEREAS, Those members who might become delinquent in the future are deterred by the prospect of loss of membership continuity and benefits; therefore be it

RESOLVED, That the moratorium on the delinquent dues provision be extended for another year; and be it further

RESOLVED, That the Committee on Constitution and Bylaws be instructed to prepare an amendment to remove the delinquent dues provision from the Society's Bylaws, for introduction in 1977.

(Financial Note: Adoption of this resolution will have a favorable financial impact, as the dues revenue of the newly-reinstated members who will rejoin will exceed the lost delinquent dues which would not have been recovered in any event, plus the additional benefit of continued dues revenues in future years.)

Discussion at the Reference Committee hearing indicated to the Reference Committee that most were in favor of continuing the moratorium on delinquent dues for one additional year, but that no Bylaws change should be made to make this feature permanent. Therefore, the Reference Committee submits the following substitute resolution:

RESOLVED, That the moratorium on delinquent dues be continued for one additional year.

Mr. Speaker, the reference committee recommends

adoption of the substitute resolution.

6. Resolution 76-23, Emeritus Membership Category

Subject: Emeritus Membership Category

Introduced by: Harold E. Swensen, M.D., Secretary, on behalf of the Allegheny County Medical Society

Author: Ralph J. Stalter, M.D.

WHEREAS, Members of component (county) medical societies are entitled to Emeritus membership status in those societies by virtue of attainment of the age of 65 years; and

WHEREAS, The Pennsylvania Medical Society has no Emeritus membership category; and

WHEREAS, The responsibility for an elder member of organized medicine to find that category of membership which best suits his ambitions and financial capabilities rests with organized medicine; therefore be it

RESOLVED, That immediately upon attainment of the age of 65 years all members will be personally notified by the Pennsylvania Medical Society of the various options of membership which are available to them at that time; and be it further

RESOLVED, That, in the event that no response from the individual members be received by the Pennsylvania Medical Society within subsequent six month period, membership in the Affiliate membership category will be automatically conferred by Pennsylvania Medical Society, and the member be so advised.

(Financial Note: Loss of approximately \$70,000 per year in dues revenue.)

Requires two-thirds vote

The reference committee heard comments on the need to notify physicians upon reaching retirement age of the various membership categories available to them, even though at the present time, county medical societies are being notified. The reference committee is in sympathy with the intent of the resolution, but submits the following resolution:

RESOLVED, That immediately upon attainment of the age of 65 years, all members will be personally notified by the Pennsylvania Medical Society of the various options of membership which are available to them at that time.

Mr. Speaker, the reference committee recommends adoption of the substitute resolution.

REFERENCE COMMITTEE REPORTS OF OFFICERS

Mr. Speaker, and members of the House of Delegates, the Reference Committee on Reports of Officers has considered all the items in the index.

1. Your reference committee has grouped the following items together in a waiver of debate list. In each instance,

there was little or no testimony heard and the committee feels the item is of a non-controversial nature.

Waiver of Debate

Report of Executive Vice President (*Official Reports Book* - pages 27-29) (File)

Report of Secretary (*Official Reports Book* - pages 29-30) (File)

Report of Treasurer (*Official Reports Book* - pages 29 & 30) (File)

Report of Accountant (*Official Reports Book* - pages 31-35) (File)

Report of Committee on Objectives (*Official Reports Book* - page 55) (File)

Report of Pennsylvania Delegation to the AMA (*Official Reports Book* - pages 79-83) (File)

Supplemental Report C, Board of Trustees and Councilors, (Appendix F of these proceedings) (File)

Supplemental Report F, Board of Trustees and Councilors (Appendix I of these proceedings) (File)

Mr. Speaker, we recommend that these items be filed.

2. Report of Board of Trustees and Councilors (*Official Report Book*, pages 14-26)

Your reference committee reviewed the entire comprehensive report of the Board of Trustees and Councilors. The Board of Trustees has recommended that the 1981 Annual Business Session be held at the Penn Harris Motor Inn, Camp Hill, Pennsylvania, Thursday, October 29, to Saturday, October 31.

Mr. Speaker, your reference committee recommends approval of the site for the 1981 House of Delegates.

Mr. Speaker, your reference committee recommends that the Report of the Board of Trustees and Councilors be filed.

3. Individual Reports from the Trustees and Councilors (*Official Reports Book* - pages 36-49)

Your reference committee reviewed the individual reports of the trustees.

Special note was taken of the report of the trustee of the Second District (page 37), which recommended discontinuance of the annual reports of trustees. However, testimony did not support this recommendation.

Mr. Speaker, we, therefore, recommend that individual reports of the trustees be continued.

In the report of the Trustee and Councilor of the Twelfth District (page 49), the Trustee noted that there seems to be discrepancy of representation throughout the State of Pennsylvania and has requested a correction of this disparity by redistricting.

Mr. Speaker, your reference committee recommends referral of this recommendation to the Committee on Constitution and Bylaws for further study.

Mr. Speaker, your reference committee recommends that the individual reports of the trustees be filed.

4. Resolution 76-8: Physicians' Union (*Official Reports Book* - page 85)

Subject: Physicians' Unions

Introduced by: John P. Whiteley, M.D., Secretary, on behalf of the York County Medical Society

Author: Joseph Danyo, M.D.

WHEREAS, The disciplines of medicine, politics, law, and insurance are becoming increasingly intertwined; and

WHEREAS, The complexities and interrelationships thereby produced are becoming very strained and alarming; and

WHEREAS, The membership of the Pennsylvania Medical Society is keenly aware of and deeply concerned about the current course of events; and

WHEREAS, The notion of physicians' unions has been alternately criticized and hailed but at the same time not fully understood; therefore be it

RESOLVED, That the Pennsylvania Medical Society shall conduct a feasibility study to determine whether a union or other such legally constructed entity offers any solution to the problem.

(Financial Note: No financial impact. However, should the thrust of this resolution be to retain a professional consulting firm to perform a detailed cost and operation analysis of a proposed union organization(s), the estimated cost falls within the range of \$10,000-\$15,000.)

Your reference committee heard testimony from a number of participants and the weight of the testimony was negative.

Mr. Speaker, your reference committee, therefore, recommends rejection of Resolution 76-8.

5. Supplemental Report E, Committee to Study Physicians' Unions (Appendix H of these proceedings)

Your reference committee considered Supplemental Report E of the Committee to Study Physicians' Unions. From the testimony received, your Reference Committee felt that the formation of a Physicians' Union as a possible method for providing organized bargaining and necessary interface with the bureaucracy and other third parties, as indicated in Supplemental Report E, would not be approved at this time. The testimony we heard, however, indicated that this activity can be carried out through the present structure of the Pennsylvania Medical Society.

Mr. Speaker, your reference committee recommends that Supplemental Report E of the Committee to Study Physicians' Unions be referred to the Board of Trustees for further study and to report their findings to the 1977 House of Delegates.

6. Address of David S. Masland, M.D., President (Appears elsewhere in this issue).

Your reference committee has reviewed the eloquent, comprehensive address of the president. Dr. Masland succinctly summarized the accomplishments of the past

year and the challenges that still lie before us. We commend him for his diligence, perseverance and dedication to his fellow physicians and commend him for his insight into the true nature of the problems that are plaguing the health care system.

Mr. Speaker, we recommend that the address of the President be filed.

7. Address of William J. Kelly, M.D., President Elect (Appears elsewhere in this issue).

Your reference committee has reviewed the comprehensive address of the president elect. Dr. Kelly has succeeded in delineating the problems and dangers facing medicine and our patients. We commend him for this address and consider the following action from the address:

I am recommending to this House an objective market research survey of the Pennsylvania Medical Society membership and the physician non-membership in this state. I want this House to order the Board of Trustees to conduct this survey of what medicine in this state wants and needs.

Your reference committee felt that many of the suggestions presented by Dr. Kelly in his address might be considered as items to be included in this survey.

Your reference committee concurs with the recommendation of the president elect.

Mr. Speaker, we recommend that the Board of Trustees be authorized to study this recommendation.

Mr. Speaker, we recommend that the address of the president elect be referred to the Board of Trustees.

REFERENCE COMMITTEE EDUCATION AND SCIENCE

Theodore A. Tristan, M.D., (Dauphin), chairman, presented the following report of the Committee:

Mr. Speaker, the Reference Committee on Education and Science has considered all the reports and resolutions listed in the index.

1. Waiver of debate list

Your reference committee groups the following items together in a waiver of debate list. In each instance there was little or no testimony heard and your reference committee feels the items are of a non-controversial nature.

Mr. Speaker, we recommend the following actions on each item:

Report of the Committee on Aid to Education (*Official Reports Book*, page 51) (Approve)

Report of the Educational and Scientific Trust (Available on request) (Approve)

Report of the Committee on Relationships With Allied Professions (*Official Reports Book*, page 55) (Approve)

2. Report of the Council on Education and Science (*Official Reports Book*, page 57)

Supplemental Report H (Appendix K of these proceedings)

This report is a wide ranging and considered summary of the Council's work. In particular your reference committee notes the Council's attempts to implement actions called for by the 1975 House of Delegates. The special projects section of this report is particularly long and pertinent, and the Council and its commissions are to be commended by this House of Delegates.

Testimony was heard by your Reference Committee with respect to item (1) under "Membership CME Standard" in Supplemental Report H of the Council on Education and Science to the effect that hospital administrators had received a copy of a county's list of physicians who had not as yet reported their requirement for membership in the Pennsylvania Medical Society.

Your Reference Committee recognizes that the Commission on Accreditation did not intend that any of this information reach any party other than the president of the medical staff of hospitals in Pennsylvania, to whom the communication was directed. Your reference committee has learned that efforts have been made to prevent a recurrence of this situation.

Mr. Speaker, we recommend the adoption of this portion of the reference committee report.

3. Report of the Committee to Study Relations between Medicine and Osteopathy (*Official Reports Book*, page 56)

Your Reference Committee heard testimony to the effect that problems of staff appointment and training for osteopathic physicians exist. Your Reference Committee recommends adoption of the report as submitted. Since there was testimony at the reference committee hearing which indicated that these relationships should be reviewed, your reference committee suggests the Committee to Study Relations Between Medicine and Osteopathy meet during the coming year to assess current relationships between osteopathic and allopathic physicians.

Mr. Speaker, we recommend the adoption of this portion of the reference committee report.

4. Resolution No. 76-10, Adoption of Traditional Medical Viewpoint of Abortion (*Official Reports Book*, page 86)

Resolution 76-10

Subject: Adoption of Traditional Medical Viewpoint of Abortion

Introduced by: John D. Lane, M.D., on behalf of the Board of Directors of Bucks County Medical Society

Author: John D. Lane, M.D.

WHEREAS, The medical profession pursues the grand and noble calling of saving human life; and

WHEREAS, Electrocardiographic evidence of heart function has been established in the embryo as early as six weeks and electroencephalographic recordings noted in the embryo at eight weeks; and

WHEREAS, Our capacity to measure the signs of life is daily becoming more sophisticated and, as time goes by, we will doubtlessly be able to isolate life signs at earlier and earlier stages in fetal development; and

WHEREAS, The prevalence of abortion in the 1850s was met with the following AMA policy:

"RESOLVED, That while physicians have long been united in condemning the procuring of abortion, at every period of gestation, except as necessary for preserving the life of either mother or child, it has become the duty of this association, in view of the prevalence and increasing frequency of the crime, publicly to enter an earnest and solemn protest against such unwarrantable destruction of human life.

"RESOLVED, That in the pursuance of the grand and noble calling we profess the saving of human life, and of the sacred responsibilities thereby devolving upon us, the association present this subject to the attention of the several legislative assemblies of the Union, with the prayer that the laws by which the crime of abortion is attempted to be controlled may be revised, and that such other action may be taken in the premises as they in their wisdom may deem necessary.

"RESOLVED, That the association request the zealous cooperation of the various state medical societies in pressing this subject upon the legislatures of the respective states, and that the president and secretaries of the association are hereby authorized to carry out, by memorial, these resolutions. (Transactions of the American Medical Association, 1859, Volume xii, page 75)"

WHEREAS, Physicians alone can rectify public opinion on medical matters and they alone can present the subject in such a manner that judges and legislators can exercise their power aright in the preparation of suitable laws; therefore be it

RESOLVED, To not let it be supposed by the public that there is among us, either in theory or practice, any disregard of the unborn child. If such impressions have already obtained from our own negligence, the falsehoods of irregular practitioners, or otherwise they should at once be removed. Fetal life ever is and ever has been held sacred by all respectable physicians; and be it further

RESOLVED, That all physicians of the state of Pennsylvania pursue this traditional medical viewpoint on abortion; and be it further

RESOLVED, That the Pennsylvania Delegates to the House of Delegates of the American Medical Association be instructed to introduce this resolution at the next meeting of that body.

(Financial Note: No financial impact.)

Resolution No. 76-10 is vague and difficult to interpret. The present position of the Society is not contrary to what your reference committee believes is intended in this resolution. The present position of the Society is:

- (1) There is documented medical evidence that continuance of the pregnancy may threaten the health or life of the mother;
- (2) There is documented medical evidence that the infant may be born with incapacitating physical deformity or mental deficiency, or
- (3) There is documented medical evidence that continuance of a pregnancy, resulting from legally established statutory or forcible rape or incest, may constitute a threat to the mental or physical health of a patient;
- (4) Two other physicians chosen because of their recognized professional competence have examined the patient and have concurred in writing; and
- (5) The procedure is performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals.

Therefore, your reference committee again asks this House of Delegates to reaffirm its present position. Each member should again reflect upon the Pennsylvania Medical Society's present policy with respect to abortion and medical ethics.

Mr. Speaker, we recommend the rejection of Resolution No. 76-10.

At this time, a motion was made from the floor that a minority report of the Reference Committee pertaining to Resolution 76-10 be substituted for the majority report.

(Secretary's Note: Sturgis Standard Code of Parliamentary Procedure, 2nd. Edition, p. 189, provides the following guidance for considering a minority report:

Minority Reports

If any members of a committee disagree with the report submitted by a majority of the committee members, they may submit a minority report signed by members who agree to it. More than one minority report may be submitted. A minority report can be presented only immediately after the majority report. A minority has the right to present and read a report, even though a motion is pending to dispose of the majority report, but the minority report is not considered unless some member moves to substitute it for the report of the majority. If the motion to substitute carries, the minority report becomes the official report of the committee and the majority report is filed for reference. If the motion to substitute fails, the minority report is filed for reference.)

The minority report pertaining to Resolution 76-10 as presented by its author, George A. Tushim, M.D., (Clinton) is as follows:

Resolution No. 76-10—Adoption of Traditional Medical

Viewpoint of Abortion (*Official Reports Book* - page 86)

The expression of support in the Reference Committee on Education and Science for Resolution No. 76-10 was approximately two to one in favor. Twenty people spoke or submitted written opinions. (I give you a summary of their thoughts.)

While the moral principles and intent of this resolution are similar to those that brought about Resolution No. 76-15, the expression of the intent is different. This resolution infers that it is the moral obligation of the physician to shun and discourage abortion except to save the life of the mother. Moreover, this obligation is ethical, unchanging and independent of the law of the land or public opinion.

There are two cornerstones of this belief:

1. The fetus is as human and living as the mother and as such possesses from nature or God an inalienable right to life. (In support of this they state that the life of the fetus in the womb is more independent than that of the newborn in that the newborn requires *active care* for its life to be maintained while the fetus requires only passive allowance for its existence.)
2. They state, either following or independent of the above belief, that liberal abortion laws lessen the respect for human life.

In the belief that this resolution reflects the ethics of the majority of those present, I call for its adoption.

Mr. Speaker, I move that the Minority Report be substituted for the report of the Reference Committee.

(Secretary's Note: This motion did not carry. The minority report was filed and the House went on to consider the report of the majority, which was sustained, i.e., the House rejected Resolution 76-10.)

5. Resolution No. 76-12, Abortion, a Major Public Health Problem (*Official Reports Book*, page 86)

Resolution 76-12

Subject: Abortion, A Major Public Health Problem

Introduced by: Frank Weiner, M.D., Indiana County;
Richard N. Freda, M.D., Indiana County

Authors: Frank Weiner, M.D.; Richard N. Freda, M.D.

WHEREAS, Approximately every twenty seconds, one unborn infant somewhere in the United States is aborted; and

WHEREAS, Almost as much human life is lost by abortion as by cardiovascular disease in the United States; and

WHEREAS, More human life is lost in the United States by abortion than by cancer, accidents, pneumonia, diabetes, and diseases of early infancy combined; therefore be it

RESOLVED, Abortion has become a major public health problem in the United States; and be it further

RESOLVED, That the Pennsylvania Delegates to the House of Delegates of the American Medical Association be instructed to introduce this resolution at the next meeting of that body.

(Financial Note: No financial impact.)

Your reference committee finds the Resolve vague and

uncertain and believes that it is another resolution intended to change the present abortion policy of the Society.

Mr. Speaker, we recommend the rejection of Resolution No. 76-12.

6. Resolution No. 76-15, Human Life Amendment to the Constitution of the United States (*Official Reports Book*, page 87)

Resolution 76-15

Subject: Human Life Amendment to the Constitution of the United States

Introduced by: William Long, M.D., Clinton County;
Dominick A. Cruciani, Jr., M.D., Lackawanna County

Authors: William Long, M.D., Dominick A. Cruciani, M.D.

WHEREAS, The Supreme Court has denied personhood to the human fetus; and

WHEREAS, The Supreme Court similarly denied personhood to the black slave (Dred Scott); and that situation was corrected by further amendment to the Constitution of the United States; and

WHEREAS, The Supreme Court has deprived the human fetus of the fundamental right to life and even the very right to have rights; and

WHEREAS, The medical profession is dedicated to the protection and preservation of human life at all stages of human development; and

WHEREAS, Organized medicine did not submit a brief to the Supreme Court demonstrating the moral obligation of the physician to preserve human life and that the physician should only perform an abortion when medically indicated; therefore be it

RESOLVED, That the Pennsylvania Medical Society support a Human Life Amendment to the Constitution of the United States; and be it further

RESOLVED, That the Pennsylvania Delegates of the American Medical Association be instructed to introduce this resolution at the next meeting of that body.

(Financial note: No financial impact.)

Your reference committee heard conflicting testimony on this resolution. After long consideration, your reference committee feels that the first resolve in Resolution No. 76-15 is clear-cut and defines the issue.

Mr. Speaker, your reference committee recommends rejection of Resolution No. 76-15.

At this time, a motion was made from the floor that a minority report of the reference committee pertaining to Resolution 76-15 be substituted for the majority report.

(Secretary's Note: Minority reports are considered in the manner prescribed by the Sturgis Standard Code of Parliamentary Procedure, as reported earlier in this section of the Proceedings.)

The minority report pertaining to Resolution 76-15 as

presented by its author, George A. Tushim, M.D., (Clinton), is as follows:

Resolution No. 76-15—Human Life Amendment to the Constitution of the United States (*Official Reports Book - page 87*)

The statements and premises of this resolution are indeed clear. If the fetus is endowed by God or nature with inalienable rights, as was the black slave of old, then this right should come at last to be recognized by the Constitution of the United States of America. If the fetus has any right at all it is the right to life. Much and varied argument was presented in favor of this resolution. Mr. Speaker, I urge that this resolution be accepted.

Mr. Speaker, I move that the Minority Report be substituted for the report of the reference committee.

(Secretary's Note: This motion did not carry. The minority report was filed and the House went on to consider the report of the majority, which was sustained, i.e., the House rejected Resolution 76-15.)

7. Resolution No. 76-17, Primary Care (*Official Reports Book, page 88*)

Subject: Primary Care

Introduced by: James R. Regan, M.D., on behalf of the Pennsylvania Society of Internal Medicine

Author: James R. Regan, M.D.

WHEREAS, The original Millis Report that originated the term, "primary care," predicted confusion; and

WHEREAS, The American Medical Association House of Delegates and the AMA testimony before Congressional committees use the term "primary care specialties," and

WHEREAS, There appears to be confusion as to the meaning of "primary care" and "primary care physicians;" and

WHEREAS, Primary care is a function, not a discipline provided by all physicians but most often by internists, pediatricians, general practitioners, obstetricians, gynecologists, and family practitioners; therefore be it

RESOLVED, That the medical specialties of family practice, internal medicine, pediatrics, and obstetrics/gynecology be recognized formally as major components of the profession which, together with general practice, provide most primary medical care to the American public; and be it further

RESOLVED, That the Pennsylvania Medical Society officials be urged to communicate this resolution to the Pennsylvania State Legislature.

(Financial Note: No financial impact.)

The testimony heard on Resolution No. 76-17 suggested that emergency medicine should be added as a primary care specialty and, therefore, while your reference committee is in accord with the second resolve, it offers a substitute for the first resolve:

RESOLVED, That the medical specialties of emergency medicine, family practice, general practice, internal medicine, obstetrics/gynecology and pediatrics be recognized formally as the components of the profession which provide most primary medical care to the American public; and be it further . . .

Mr. Speaker, we recommend adoption of the amended resolution.

(Secretary's Note: The recommendation of the reference committee was not adopted. The following amendment to first resolve of Resolution 76-17 was introduced from the floor and adopted: 'RESOLVED, That while family and general practice are recognized as the major deliverers of primary health care, that the medical specialties of internal medicine, pediatrics, obstetrics/gynecology and emergency medicine also be recognized as components of the profession which provide primary medical care to the American public, and be it further . . .')

The resolution, as adopted, reads:

Resolution 76-17

Subject: Primary Care

Introduced by: James R. Regan, M.D., on behalf of the Pennsylvania Society of Internal Medicine

Author: James R. Regan, M.D.

WHEREAS, The original Millis Report that originated the term, "primary care," predicted confusion; and

WHEREAS, The American Medical Association House of Delegates and the AMA testimony before Congressional committees use the term "primary care specialties," and

WHEREAS, There appears to be confusion as to the meaning of "primary care" and "primary care physicians;" and

WHEREAS, Primary care is a function, not a discipline provided by all physicians but most often by internists, pediatricians, general practitioners, obstetricians, gynecologists, and family practitioners; therefore be it

RESOLVED, That while family and general practice are recognized as the major deliverers of primary health care, that the medical specialties of internal medicine, pediatrics, obstetrics/gynecology and emergency medicine also be recognized as components of the profession which provide primary medical care to the American public, and be it further

RESOLVED, That the Pennsylvania Medical Society officials be urged to communicate this resolution to the Pennsylvania State Legislature.

[Financial Note: No financial impact.]

REFERENCE COMMITTEE GOVERNMENTAL RELATIONS

Robert N. Moyers, M.D. (Crawford) chairman, presented the following report of the committee:

Mr. Speaker, the Reference Committee on Governmental Relations has considered all of the material listed in the index.

1. Report of the Council on Governmental Relations (*Official Reports Book*, page 64)

The reference committee is pleased with the work done by the Council this past year, especially by its Commission on Forensic Medicine concerning Resolution 75-22, Expulsion of the Professional Expert Witness from the Pennsylvania Medical Society. The results of this work were evident to all delegates in the proposed amendments to the Society's Bylaws.

The committee was also pleased that the Council will shortly be supporting in the Pennsylvania General Assembly model legislation recently prepared by the American Medical Association and recommended last year by Dr. Masland in his address to this house. The legislation will be designed to tighten up the availability of patients' medical records, thereby enhancing the physician/patient relationship.

Your reference committee is also pleased with the Council's current achievements and plans for further amendments to Act 111, most of which originated from Dr. Crane and the ad hoc committee.

Mr. Speaker, your reference committee recommends that the report of the Council on Governmental Relations be filed.

2. Supplemental Report of the Council on Governmental Relations (Appendix G of these proceedings)

The supplemental report of the Council should be "must" reading for every member of the Society. Your reference committee hopes that each of you will take it back and discuss it with your county society as it contains the history of individual bills in which we have had an interest during the 1975-76 Session of the Pennsylvania General Assembly. It recounts in capsule all of the critical campaigns we have all had an interest in during this two-year session. The twenty-nine categories listed by the Council include reports on such bills as the Shapp "Comprehensive Health Planning" bills, the Society's work in improving the State's emergency medical systems, the Society's activity in getting the Legislature's personal concern in the administration of the state's medicaid program, and many others. Again, may we please urge you to share this report with your county societies when you return.

Mr. Speaker, your reference committee recommends that the Supplemental Report of the Council on Governmental Relations be filed.

3. Report of the Committee on Discipline (*Official Reports Book*, page 54)

The Committee on Discipline reports that it is awaiting final regulations to be promulgated by the State Board of Medical Education and Licensure in order to ascertain if additional legislation is needed in the medical disciplinary area. Your reference committee would recommend that the Committee on Discipline hold its scheduled meeting in 1977 and report back to this house its findings.

Mr. Speaker, we recommend that the report of the Committee on Discipline be filed.

4. Resolution 76-2 -H.R. 599, Radiation Health Care and Safety Act of 1975 (*Official Reports Book*, page 83)

Subject: H.R. 599, Radiation Health and Safety Act of 1975
Introduced by: Edward J. Resnick, M.D., Secretary, on behalf of the Philadelphia County Medical Society

Author: Edward J. Resnick, M.D.

WHEREAS, This bill (H.R. 599) "would give an unprecedented authority to the federal government to regulate and to control educational programs and personnel related to essential health care services," and it would also establish criteria for "education institutions conducting programs for the training of medical and dental practitioners"; and

WHEREAS, It is the position of the American Medical Association that "this proposal is unnecessary and unwarranted, and we recommend its rejection"; therefore be it

RESOLVED, That the Pennsylvania Medical Society support the position of the American Medical Association in opposition to H.R. 599; and be it further

RESOLVED, That the Pennsylvania Medical Society support efforts to prevent enactment of this legislation. (Financial Note: No financial impact.)

Your reference committee heard testimony to the effect that this proposal, currently before Congress, would give an unprecedented authority to the federal government to regulate and control educational programs and personnel related to essential health services.

Mr. Speaker, your reference committee recommends adoption of Resolution 76-2.

5. Resolution 76-5, Patient Notification - Clinical Laboratory Act (*Official Reports Book*, page 84)

Subject: Patient Notification—Clinical Laboratory Act
Introduced by: Edward J. Resnick, M.D., Secretary, on behalf of the Philadelphia County Medical Society

Author: Board of Directors of the Philadelphia County Medical Society

WHEREAS, Rules and regulations controlling clinical laboratories in the Commonwealth of Pennsylvania require that "a notification of all charges for laboratory tests performed for the patient must be sent to the patient by the clinical laboratory unless the patient has been billed directly or otherwise notified"—(28 Pa. Code, Chapter 5, 5.48); and

WHEREAS, Such notification is utterly meaningless unless identified with specific tests; and

WHEREAS, Any identification of tests provided as a part of such notification or arising out of such statement of cost would increase their danger of violation of privacy with deleterious effects on family relationships, as well as increasing the reluctance of patients to have tests done for pregnancy and venereal diseases while facing such disclosure; and

WHEREAS, The cost to patients incurred by mailing of the statements develops further increases in laboratory

costs; therefore be it

RESOLVED, That this Section (5.48) of the regulations be repealed or held in abeyance.

(Financial Note: Financial impact difficult to estimate; depends on actions planned.)

This resolution asks the Society to oppose rules and regulations promulgated under the Clinical Laboratory Act which require that "A notification of all charges for laboratory tests performed for the patient by an independent laboratory must be sent to the patient by the clinical laboratory unless the patient has been billed directly or otherwise notified."

Mr. Speaker, your reference committee recommends adoption of Resolution 76-5.

6. Resolution 76-21, Mental Health Procedures Act 143

Subject: Mental Health Procedures Act 143

Introduced by: Rex A. Pittenger, M.D., Allegheny County

Author: Rex A. Pittenger, M.D.

WHEREAS, The Pennsylvania Legislature has passed a bill, Act 143, relating to procedures for Pennsylvania residents to enter the mental health treatment programs; and

WHEREAS, The regulations promulgated on September 4, 1976 require that all psychiatric inpatient admissions be reported to the county administrator; and

WHEREAS, This process intrudes on the relationship of the doctor and his patient and the confidentiality required; therefore be it

RESOLVED, That the staff and members of the Pennsylvania Medical Society participate with other concerned persons in removing any requirement of reporting names of voluntary private patients; and be it further

RESOLVED, That the staff and members work with state and county mental health/mental retardation staffs to devise mechanisms whereby all applications, certificates, and records of all patients remain under professional jurisdiction to the maximum extent possible.

(Financial Note: No financial impact.)

Requires two-thirds vote

Your reference committee heard testimony in support of not only this resolution but for additional changes in the Act itself. These suggested amendments to the law, your committee understands, will be forthcoming from the Pennsylvania Psychiatric Society at a future date. Since this resolution calls for changes in regulations which can be undertaken now, we are in support of it and will anxiously await the suggested changes in the Act which can be considered by the Board of Trustees.

Mr. Speaker, your reference committee recommends adoption of Resolution 76-21.

7. Address of the President Elect, Portion on Medical School Admissions

The reference committee heard testimony from Dr. Kelly about the desirability of having more Pennsylvania residents enrolled in Pennsylvania medical schools. It was

clear to your committee that more information is needed before the Society can design legislation, as suggested in Dr. Kelly's presentation. Dr. Kelly reported that statistics were available through the State Board of Medical Education and Licensure that, if requested, could be turned over to the State Society for study. Accordingly, your reference committee recommends that Dr. Kelly's remarks concerning medical school admissions be referred to the Board of Trustees with the suggestion that they ask Dr. Kelly and the State Board of Medical Education and Licensure for all available data. Your reference committee further recommends that, prior to the Society's designing any legislation, a meeting with the deans of the medical schools be sought in an effort to correct the problem "in the family."

Mr. Speaker, your reference committee recommends adoption of the reference committee's report.

REMARKS OF A. REYNOLDS CRANE, M.D., PAST PRESIDENT

"The stimulating remarks of my fellow alumnus from Cornell, Dr. Emerson, have moved me to rise to comment on the merit selection of judges for the benefit particularly of this House. This is a project in which this Society has been actively involved. When I was president I spent three days in the workshop in Hershey developing a plan for the merit selection of judges. I have served on the statewide committee, as has Dr. Masland. You will find our names listed on the letterhead of the activities—we have participated actively in this so that I would say to the bar association and to Mr. Gallagher and to this House that this is something in which we firmly believe and which we wholeheartedly support, and they will have our efforts to the final end.

"In the same vein, I think it is incumbent upon this House and this Society to ask the Pennsylvania Bar Association and Mr. Gallagher for their support in our efforts to have adopted a merit system for the selection of expert medical witnesses."

CHANGE IN AGENDA

A motion was made from the floor of the House that the following day's program be altered whereby the scheduled councilor district caucuses would be cancelled and the House would reconvene one hour early, at 8:30 a.m. The motion was adopted. The Speaker announced that the polls would open at 7:00 a.m. and close at 9:00 a.m.

RECESS

The House recessed at 4:15 p.m. until the opening of the final session at 8:30 a.m., Saturday, September 18.

Twenty-ninth State Dinner

Prior to the 1976 State Dinner, a reception was held in the Clover and Red Rooms of the Bellevue-Stratford Hotel. As in past years, this reception was courtesy of the Frank B. Hall Company, Inc. of Pennsylvania. At 8:00 p.m.,

all those present moved to the Grand Ballroom where dinner was served.

The invocation was given by Rev. John M. Unger, pastor of the Sacred Heart Church in Pittsburgh and personal pastor to Dr. William J. Kelly, incoming president.

Introduction of Dignitaries

In order to shorten the official program of State Dinner, Dr. Masland dispensed with the formal introduction of the head table, guests of the Society, and the past presidents of the Society. Those introduced were: Mr. Lester Perry, former executive director of the Pennsylvania Medical Society; Mr. and Mrs. Robert E. Rinehimer, president of Pennsylvania Blue Shield; Dr. and Mrs. Russell B. Roth, PMS member and past president of the American Medical Association; Dr. and Mrs. William Y. Rial, vice speaker of the American Medical Association House of Delegates. Dr. Masland also introduced those members of his family who were present at the State Dinner.

Presentation of Gavel to Immediate Past President of the Pennsylvania Medical Society Auxiliary

Dr. Masland presented the Past President's Gavel to Mrs. Richard T. Smith, immediate past president of the Pennsylvania Medical Society Auxiliary in recognition of her services as president of the Auxiliary during the year ending with the 1976 Auxiliary House of Delegates.

Installation of the President

Dr. George A. Rowland, chairman of the Board of Trustees of the Pennsylvania Medical Society, installed Dr. William J. Kelly, Allegheny County, as the 127th president of the Pennsylvania Medical Society. After taking the oath of office, Dr. Kelly delivered brief remarks and introduced those members of his family present at State Dinner.

Presentation of Past President's Medallion

Dr. Rowland presented the Past President's Medallion and Plaque to Dr. David S. Masland, Cumberland County, in tribute to his great efforts in behalf of the Pennsylvania Medical Society as its 126th president.

Presentation of Distinguished Service Award

As his first official act, Dr. Kelly presented the Pennsylvania Medical Society's Distinguished Service Award to Dr. John B. Hubbard, Philadelphia. Dr. Kelly cited Dr. Hubbard as being an outstanding medical educator and pioneer cardiologist who is internationally recognized for his leadership in medical education. Along with his classmate, Dr. Robert Gross, Dr. Hubbard is credited with the beginning of the era of heart surgery as a result of the publication of a report of the first successful ligation of a patent ductus arteriosus. Dr. Kelly noted that in the 26-year history of this award program, only six other physicians have been named recipients of the Distinguished Service Award.

Adjournment

The formal portion of the program adjourned at 9:15

p.m. Members and their guests were entertained until 12 p.m. by a musical anthology entitled "Three On Broadway" and music provided by Paul Mann's Miss America Pageant Orchestra.

Final Session of the House of Delegates September 18, 1976

The final session of the 1976 Annual Session of the House of Delegates was called to order in the Grand Ballroom of the Bellevue-Stratford Hotel, Philadelphia, Saturday, September 18, 1976, at 8:30 a.m.

Dr. David A. Smith (Dauphin) reported that a quorum was in attendance. As announced on the previous day, the polls were closed at 9:00 a.m.

REFERENCE COMMITTEE MEDICAL SERVICE A

R. William Alexander, M.D., (Berks) chairman, presented the report of the committee, as follows:

1. Mr. Speaker and members of the House of Delegates: The Reference Committee on Medical Service A has considered all of the reports and resolutions listed in the index. Your reference committee has grouped the following items together in a waiver of debate list. In each instance, there was little or no testimony heard and the committee feels the item is of a non-controversial nature.

Supplemental Report G of the Council on Medical Service (Appendix J of these Proceedings) (File)

Resolution 76-1: Act 111 - Removal of the Mandatory Physician Malpractice Insurance Coverage (*Official Reports Book*, page 83) and Item 1 of the Report from the Ninth Councilor District (*Official Reports Book*, page 45) (Approve)

Resolution 76-4: Reimbursement for D.P.W. Outpatient Services (*Official Reports Book*, page 84) (Approve)

Resolution 76-9: Better Support for Hemodialysis Done in the Home (*Official Reports Book*, page 85) (Approve)

Resolution 76-22: Medicaid Reimbursement (Approve)

Resolution 76-26: Audit of Government Programs (Approve)

Report of the Board of Trustees and Councilors concerning the actions of the Ad Hoc Committee on Malpractice Insurance (*Official Reports Book*, page 20) (File)

Resolution 76-1

Subject: Act 111—Removal of the Mandatory Physician Malpractice Insurance Coverage

Introduced by: Edward J. Resnick, M.D., Secretary, on behalf of the Philadelphia County Medical Society

Author: Edward J. Resnick, M.D.

WHEREAS, There are many communities in Pennsylvania

nia in which there is a shortage of available physicians' service; and

WHEREAS, Many elderly physicians and partially disabled physicians are able to provide medical care for some patients; and

WHEREAS, The current provision of the Health Care Services Malpractice Act 111 provides that all physicians practicing in the Commonwealth of Pennsylvania must carry \$100,000/\$300,000 limits of coverage in spite of part-time or minimal practice; and

WHEREAS, A requirement to have insurance without any option for self-insurance or provision of other forms of protection, is by provision of the Act forcing many of these physicians to discontinue their practices entirely; therefore be it

RESOLVED, That the Pennsylvania Medical Society work to amend the Health Care Services Malpractice Act (Act 111) to remove the mandatory malpractice coverage provision.

(Financial Note: No financial impact.)

Resolution 76-4

Subject: Reimbursement for D.P.W. Outpatient Services
Introduced by: Edward J. Resnick, M.D., Secretary, on behalf of the Philadelphia County Medical Society

Author: George R. Fisher, M.D.

WHEREAS, The Pennsylvania State Department of Public Welfare reimburses hospital outpatient departments \$9.00 per visit, and only reimburses private practitioners \$6.00 per visit; and

WHEREAS, The basis for such inequality is claimed to be a Utilization Review Program, but in fact there is no evidence of such program; and

WHEREAS, Several bodies of the medical societies are capable of providing utilization service if there is a sincere wish to have it; therefore be it

RESOLVED, That the Department of Public Welfare be urged to make reimbursement for outpatient care equal between practitioners and hospital outpatient departments; and be it further

RESOLVED, That outpatient services, regardless of where rendered, should be reasonably reimbursed.

(Financial Note: No financial impact.)

Resolution 76-9

Subject: Better Support for Hemodialysis Done in the Home

Introduced by: Richard A. Kern, M.D., Philadelphia County
Author: Richard A. Kern, M.D.

WHEREAS, The financing of life-preserving care to victims of end-stage renal disease has become accepted as the responsibility of government; and

WHEREAS, Maintenance hemodialysis yields the best results when carried out in the patient's home, both in patient survival (e.g., in the Philadelphia Metropolitan Area, the annual death rate of patients on home dialysis is 15 percent, as compared with 20 percent for those treated in Hospital and Center Dialysis facilities) and in psychological and economic rehabilitation; and

WHEREAS, The decline in home dialysis is a result of a lack of incentives, by federal and state reimbursement programs, to encourage patients to choose home dialysis, indeed, those programs actually penalize those on home dialysis (for example, by failing to cover various supplies and drugs used by such patients, while they are covered when used in centers); and

WHEREAS, The cost of home dialysis is materially less than that of center dialysis (the home dialysis cost per patient is \$14,900 in the first year, including initial purchase of equipment, supplies, and maintenance, and \$7,000 yearly thereafter, as compared with an average of \$23,400 yearly per patient in center dialysis facilities); and

WHEREAS, Certain *financial incentives* to encourage home dialysis (such as removing the 3-month waiting period after beginning home training, increasing present 80 percent coverage to 100 percent, including drugs and supplies; reimbursement of the home dialysis partner) are not only financially possible, but able, by increasing home dialysis usage, to effect savings of government funds; therefore be it

RESOLVED, That the Pennsylvania Medical Society urge the Secretary of the Department of Health, Education, and Welfare of the United States, the Commissioner of the Social Security Administration, and the Secretary of Health of the Commonwealth of Pennsylvania to consider the revision of existing reimbursement policies, along the lines suggested, (and amply justified by the study of the Hospital Survey Committee, Inc., in its report, "Hemodialysis Services and Facilities" of June 1976) so as to encourage a more wide-spread use of home dialysis as an alternative to center (hospital or free-standing facilities) maintenance dialysis; and be it further

RESOLVED, That the Pennsylvania Medical Society instruct its Delegates to the American Medical Association to urge the American Medical Association to take similar action at the national level.

(Financial Note: No financial impact.)

Resolution 76-22

Subject: Medicaid Reimbursement

Introduced by: Harold E. Swensen, M.D., Secretary, on behalf of the Allegheny County Medical Society

Author: Matthew Marshall, Jr., M.D.

WHEREAS, Pennsylvania's medicaid fee schedule is the lowest in the nation; and

WHEREAS, Such a low fee schedule discourages physicians from practicing in low income areas in Pennsylvania; and

WHEREAS, Pennsylvania's physicians' willingness to take care of welfare recipients at such a low fee has probably contributed to the continued lack of improvement of those fees; therefore be it

RESOLVED, That the Legislature be informed that inadequate reimbursement of physicians contributes to the physician shortage of low income areas in Pennsylvania; and be it further

RESOLVED, That the Pennsylvania Medical Society take all available steps to improve this situation as soon as possible.

(Financial Note: No financial impact)

Requires two-thirds vote

Resolution 76-26

Subject: Audit of Government Programs

Introduced by: Milton M. Perloff, M.D., on behalf of the Philadelphia County Medical Society

Author: Milton M. Perloff, M.D.

WHEREAS, Senator Henry G. Hagar has called upon a large number of leaders of medicine in Pennsylvania to respond to his call for suggestions for pinpointing government intervention which wastes overtime and money; and

WHEREAS, He proposes to follow up these responses with an audit of government functions with an objective of correcting abuses and waste; and

WHEREAS, This type of review and audit usually concludes with a review of many divergent points of view and little real accomplishment; therefore be it

RESOLVED, That the Pennsylvania Medical Society be asked to undertake to solicit and assemble recommendations which are appropriate to this program from County Medical Societies and physicians and to then assemble these suggestions into a single organized presentation; and be it further

RESOLVED, That this composite of recommendations then be forwarded to Senator Hagar for his use.

(Financial Note: No financial impact)

Requires two-thirds vote

Mr. Speaker, your reference committee recommends that the House take the actions recommended by the committee on the above listed items.

(Secretary's Note: The Speaker divided the recommendation of the reference committee in order that the House could consider each item separately. In each case, the recommendation of the reference committee was sustained.)

2. Report of the Council on Medical Service (*Official Reports Book*, pages 66-74) and Item 3 from the Report of the Ninth Councilor District (*Official Reports Book*, page 45)

Your reference committee considered the report of the Council on Medical Service as a whole and commends the Council and staff for its efforts during the past year. Additionally, your reference committee considered Item 3 from the Report of the Ninth Councilor District as it addresses the same subject area.

Resolution 75-19: Blue Shield Fees was considered separately, in view of the recommendation by the Council calling for a detailed examination of the practical results and effect of a Statewide Level II.

Your reference committee heard extensive testimony both by interested physicians and Blue Shield representatives. Among the various items considered were anti-trust implications; possible law suits by physicians in the metropolitan areas; and possible loss of participating Blue Shield physicians. While the reference committee

recognized that change to a single charge class would increase fees to some physicians, it would also decrease fees to others and the reference committee was not convinced that the change would encourage more physicians to set up practice in more rural areas.

The extensive testimony developed no new evidence beyond that contained in the report of the Council on Medical Service and the report of the feasibility of implementation presented by Blue Shield.

In light of the above, your reference committee did not consider that the testimony was conclusive. Therefore, your reference committee believes that this question should be returned to the Council on Medical Service for its continued evaluation.

Mr. Speaker, your reference committee recommends adoption of this portion of the reference committee's report and re-referral of Resolution 75-19 to the Council for continued evaluation.

(Secretary's Note: Resolution 75-19 is as follows:

Subject: Blue Shield Fees

Introduced By: O. K. Stephenson, M.D., Secretary, on behalf of the Perry County Medical Society

Author: O. K. Stephenson, M.D.

WHEREAS, Equal pay for equal work is a fundamental principle of equity; and

WHEREAS, The present Blue Shield fee schedule does not provide equal pay for equal work and is thus inequitable and discriminatory; therefore be it

RESOLVED, That the Pennsylvania Medical Society recommend to Pennsylvania Blue Shield the adoption of a uniform fee schedule throughout the state.

[1975 Secretary's Note: The House turned down the recommendation of the reference committee and approved Resolution 75-19 with an amended resolve which reads: "RESOLVED, That the Pennsylvania Medical Society recommend the adoption of a uniform charge class for all prevailing fee plans throughout the state."]

3. Report from Pennsylvania Blue Shield (Available on request)

Your reference committee accepted this report as informational.

Mr. Speaker, your reference committee recommends that the 1976 Report from Pennsylvania Blue Shield be filed.

4. Resolution 76-14: Assessment—Loans by County Medical Societies (*Official Reports Book*, page 87)

Subject: Assessment

Introduced by: Harmon J. Machanic, M.D., Lycoming County

Author: Harmon J. Machanic, M.D.

WHEREAS, Argonaut Insurance Company has harassed individual physician members and Pennsylvania Medical Society officers at all levels in regard to malpractice insurance; and

WHEREAS, The Pennsylvania Medical Society may need to raise millions of dollars rapidly; and

WHEREAS, The levying and collection of individual assessments by the Pennsylvania Medical Society may take a considerable period of time; and

WHEREAS, It is necessary that so far as possible, all segments of the physician population of Pennsylvania be directly involved in setting up the captive insurance company; therefore be it

RESOLVED, That the county medical societies be urged to immediately pass resolutions authorizing each county society treasurer to sign a note covering the expected assessment against the membership of each county society then immediately forwarding to the captive medical insurance company the amount so raised by the bank loan should the Board of Trustees of the Pennsylvania Medical Society decide this method of fund raising be necessary; and be it further

RESOLVED, That so far as possible the members of each county society be urged to help in the raising of the assessment levied for paying back the monies borrowed. (Financial Note: No financial impact.)

Your reference committee heard only testimony in the negative and, while the reference committee feels that the intent of this resolution is meritorious, it appears to be an impractical and unworkable solution.

Mr. Speaker, your reference committee recommends rejection of Resolution 76-14.

5. Resolution 76-19: Pennsylvania Blue Cross and Blue Shield Merger, Feasibility Study

Subject: Pennsylvania Blue Cross and Blue Shield Merger, Feasibility Study

Introduced by: Domenick A. Cruciani, M.D., President and Delegate, on behalf of the Lackawanna County Medical Society

Author: Joseph N. Demko, M.D.

WHEREAS, Pennsylvania Blue Shield and the five Pennsylvania Blue Cross plans are separate and distinct corporations having similar and overlapping missions; and

WHEREAS, It is usually more economical to manage one as compared to six corporations; and

WHEREAS, The primary mission of Blue Cross is to pay for in-patient care and services; and

WHEREAS, The primary mission of Blue Shield is to pay for in-patient and out-patient physician care and services; and

WHEREAS, The economic strategies and policies of one corporation are often at conflict with the others; and

WHEREAS, These conflicting strategies and policies often have an undesirable and confusing impact on both physicians and patients; and

WHEREAS, The Pennsylvania Medical Society has a duty, both to its physician members and their patients, to see that these corporations are run in as fair and economical a manner as possible; therefore be it

RESOLVED, That the Pennsylvania Medical Society initiate a study to determine the desirability and feasibility of a merger of Pennsylvania's Blue Cross plans and Pennsylvania Blue Shield.

(Financial Note: No financial impact. However, should the

thrust of this resolution be to retain professional consulting assistance, the cost of such assistance could be significant—\$15,000 plus.)

Requires two-thirds vote

Your reference committee heard no testimony in support of this Resolution. Testimony revealed that there are currently several areas of governmental pressure being applied to the Blues which require those Plans to carefully examine the feasibility and advisability of merger. Additionally, your reference committee believes that the existing liaison responsibility of the Council on Medical Service with Pennsylvania Blue Shield is adequate to monitor developments in this area.

Mr. Speaker, your reference committee recommends rejection of Resolution 76-19.

(Secretary's Note: This resolution was referred to the Council on Medical Service for further consideration.)

6. Resolution 76-20: Payments to Physicians in Teaching Setting by Medicare Fiscal Intermediary

Subject: Payments to Physicians in Teaching Setting by Medicare Fiscal Intermediary

Introduced by: Herbert C. Dodge, M.D., Anesthesiology
Author: Herbert C. Dodge, M.D. (Anesthesiology) and Executive Committee of the Pennsylvania Society of Anesthesiologists

WHEREAS, The intern and residency training programs for anesthesiology and other medical specialties are vital to the delivery of health care in this commonwealth; and

WHEREAS, The Pennsylvania Medical Society strongly supports the continuation, upgrading and expansion of such programs; and

WHEREAS, The continued existence of such programs is dependent upon the willingness of private physicians to supervise and teach the interns and residents in the area of their specialty; and

WHEREAS, The teaching physicians provide clinical access to their own private patients for such purposes and they rely upon the fees from such services for their livelihood; and

WHEREAS, The past practice of Pennsylvania Blue Shield under Medicare and under its own health insurance plans has been to reimburse teaching physicians in full for services to a patient notwithstanding the fact that interns or residents had been permitted to participate in the care of the patient under the direct supervision of the teaching physicians; and

WHEREAS, Pennsylvania Blue Shield has advised this Society that effective October 1, 1976, it will no longer reimburse teaching anesthesiologists for their full fee if part of the services to a patient have been physically performed by an intern or resident under the supervision of the anesthesiologist; and

WHEREAS, The reduction of income that will be imposed upon teaching physicians if they permit interns and residents to engage in direct services to their patients will have the effect of eliminating the direct involvement of interns and residents in services to patients in the

specialty of anesthesiology and thus elimination of the practical experience which is the critical element of such graduate training programs; and

WHEREAS, Such action by Blue Shield will seriously jeopardize or eliminate all graduate training programs in the specialty of anesthesiology in the Commonwealth of Pennsylvania, at a time when anesthesiologists are recognized by Congress to be in short supply, and any other specialty training program with regard to which Blue Shield should take similar action; and

WHEREAS, There are currently numerous Pennsylvania residency training programs in anesthesiology which, when combined, train approximately 10 percent of all new anesthesiologists nationwide; and

WHEREAS, The changes in the practice of anesthesiology within the Commonwealth of Pennsylvania that would result if this action by Blue Shield prevails, would seriously affect patient care, hospital procedures, and the practice of surgery by decreasing the availability of anesthesiologists for respiratory care, pain control and management, cardio-pulmonary resuscitation, intensive care units, and interdepartmental continuing medical education; and

WHEREAS, Blue Shield's present action is directed only against anesthesiology, it can be seen as a forerunner of future action against other services; therefore be it

RESOLVED, That the Pennsylvania Medical Society shall oppose any such action, and in particular the reduction of fees to teaching anesthesiologists, by Blue Shield either in its capacity of Medicare Intermediary or on its own behalf which will jeopardize graduate teaching programs in anesthesiology or any other medical specialties. Such opposition shall include communications with Blue Shield and the appropriate Federal administrative agencies and, if legal action is brought by any individuals or organization to enjoin such action on the part of Blue Shield, participation in such suit by the filing of amicus curiae briefs with the court; and be it further

RESOLVED, That Pennsylvania Medical Society notify all recognized specialty societies in Pennsylvania of this action and encourage those societies to undertake similar notification of Medicare of their concerns over this action, either independently or through their national organization; and be it further

RESOLVED, That Pennsylvania Delegates to the House of Delegates of the American Medical Association be instructed to introduce this resolution, calling for similar action, at the next meeting of that body.

(Financial Note: At least \$5,000 if it is necessary to file amicus curiae briefs.)

Requires two-thirds vote

Testimony presented was strongly in favor of this resolution and indicated a considerable difference in interpretation of the reimbursement guidelines as presented by the Bureau of Health Insurance. These differences are currently being studied and no implementation date for the new guidelines has been established.

Your reference committee is aware of the undesirable

effects such guidelines could have not only to anesthesiologists, but to all medical specialties and believes that strong support by the Society is indicated. However, your reference committee did not believe that it would be appropriate at this time for the Society to commit itself irrevocably to costly legal action as is suggested by the original resolution.

Mr. Speaker, your reference committee recommends approval of Resolution 76-20 with the following amended Resolve:

"RESOLVED, That the Pennsylvania Medical Society shall oppose any such action, and in particular the reduction of fees to teaching anesthesiologists, by Blue Shield either in its capacity of Medicare Intermediary or on its own behalf which will jeopardize graduate teaching programs in anesthesiology or any other medical specialties. Such opposition shall include communications with Blue Shield and the appropriate Federal administrative agencies and, if legal action is brought by any individuals or organization to enjoin such action on the part of Blue Shield, *consideration of participation in such suit shall be considered by the Pennsylvania Medical Society; and be it further resolved . . ."*

(Secretary's Note: The amended resolve above was further amended from the floor removing the words "consideration of" in the third line from the bottom. The amended resolution was adopted as further amended.)

7. Resolution 76-25: Blue Shield

Subject: Blue Shield

Introduced by: Milton M. Perloff, M.D., on behalf of the Philadelphia County Medical Society

Author: Milton M. Perloff, M.D.

WHEREAS, Blue Shield has, since its inception, been identified as the "Doctors' Plan," and

WHEREAS, Blue Shield has been advertised as a program to provide a prepayment mechanism for payment of all physician professional fees, and

WHEREAS, Blue Shield has from time to time put into effect regulations which deny payment of physician fees in certain instances (e.g. (1) payment for laboratory work unless for a specific and confirmed diagnosis (2) apparently erratic applications of regulations with respect to payment for varying numbers of EKGs (3) payment for items such as stress tests), and

WHEREAS, Blue Shield subscribers, as a result of advertising and previous provision of benefits have come to expect that Blue Shield will function as a comprehensive payment mechanism, and

WHEREAS, These denials of payment by Blue Shield are based on purely economic factors, and

WHEREAS, Blue Shield advises subscribers that these denied payments represent unnecessary or inappropriate care as a part of its denial process and physicians are thereby forced into explanation and justification of the propriety of their professional services; therefore be it

RESOLVED, That the Pennsylvania Medical Society insist that Blue Shield make payments for physician services on a comprehensive basis or spell out in specific

detail the items of care for which payment will not be made, and inform subscribers of the fact that lack of reimbursement for certain services is an insurance contractual relationship and has nothing to do with appropriate medical care; and be it further

RESOLVED, That if Blue Shield does not discontinue this practice and other unreasonable harassment of physicians that the House of Delegates of the Pennsylvania Medical Society take action terminating the formal relationship between Blue Shield and the Pennsylvania Medical Society and urge physicians to discontinue their status as participating physicians in Blue Shield.

(Financial Note: No financial impact)

Requires two-thirds vote

Your reference committee is sympathetic with the intent of this resolution, but cannot approve it as written. The resolution brings out several misunderstandings on the part of both physicians and subscribers as to the operation and duty of Pennsylvania Blue Shield as a health care insurer. Your reference committee does not support this resolution because the points raised are not practical and in some cases, inaccurate. In addition, we heard no testimony in support of this resolution.

Your reference committee is aware that the Council on Medical Service, as a part of its ongoing responsibilities, is aware of and pursuing a better understanding in this area and Blue Shield representatives also indicated their full cooperation.

Mr. Speaker, your reference committee recommends rejection of Resolution 76-25.

8. Resolution 76-28: Definition of Stillborn, Act 66 of the General Assembly of 1953 (The Vital Statistics Act)

Subject: Definition of Stillborn, Act 66 of the General Assembly of 1953 (The Vital Statistics Act)

Introduced by: David P. Morrison, Jr., M.D., Secretary on behalf of the Bucks County Medical Society

Author: David P. Morrison, Jr., M.D.

WHEREAS, Act 66 defines a stillborn as a fetus of 16 weeks or greater; and

WHEREAS, The point of survival or viability is defined as 28 weeks or greater; and

WHEREAS, The requirements of the Act have caused considerable difficulty, expense and emotional trauma to many patients and families; and

WHEREAS, This portion of the Act is not in agreement with similar regulations in many other states; and

WHEREAS, A reasonable definition of a stillborn would be a fetus of 500 grams or greater and/or a gestational age of 22 weeks; therefore be it

RESOLVED, That the Pennsylvania Medical Society take an official position of favoring a change in the legal definition of a stillborn as it applies to Act 66; and be it further

RESOLVED, That the Pennsylvania Medical Society actively pursue the introduction and passage of legislation to accomplish this end.

(Financial Note: No financial impact.)

Requires two-thirds vote

Your reference committee heard no testimony either pro or con on this resolution and recommends that this matter be referred to the appropriate body of the Society for study and proper disposition.

Mr. Speaker, your reference committee recommends referral of Resolution 76-28.

9. Report of the Ninth Councilor District, Item 4 (*Official Reports Book*, page 45)

Your reference committee is aware of the continuing activities of the Council on Medical Service's Commission on Health Planning in working with Health Service Areas (HSAs) across the state and believes the Commission could be of assistance to physicians in Butler County.

Mr. Speaker, your reference committee recommends referral of Item 4 from the Report of the Ninth Councilor District.

ANNUAL ASSESSMENT

Leroy A. Gehris, M.D., Chairman of the Finance Committee of the Board of Trustees and Councilors, presented the following report containing the recommendation of the Finance Committee that the annual assessment for full dues paying members be \$150 for 1976.

"Mr. Speaker, members of the House of Delegates, the Board of Trustees recommends that the 1977 annual assessment for active members of the Pennsylvania Medical Society be \$150.

"Contingent upon the approval by the House of the 1977 assessment, the Finance Committee plans to introduce a resolution before the Board of Trustees which will recommend that 5.33 percent of the annual assessment be allocated to the Educational Fund of the Educational and Scientific Trust of the Pennsylvania Medical Society, which in the case of full dues paying members will amount to \$8.00.

"The Finance Committee also plans to recommend to the Board of Trustees that of the annual assessment paid by each active dues paying member, .67 percent, or \$1.00 in the case of full dues paying members, be allocated to the Medical Benevolence Fund.

"This means that \$141 of the annual assessment of each full dues paying member will be available to the General Fund for operating expenses of the Society."

EXPRESSION OF THANKS

A motion was made from the floor that the Society express its gratitude to the Bellevue-Stratford Hotel for the outstanding manner in which services for Annual Session were provided. The motion passed.

REAFFIRMATION OF CAPTIVE INSURANCE COMPANY ASSESSMENT

In a special report of the Reference Committee on Medical Service A presented on Friday, September 17, the House approved a general assessment of \$500 of all full dues paying members and a proportionate assessment of all other dues paying categories in order to capitalize the Pennsylvania Medical Society Liability Insurance Company. The House also voted to amend the Bylaws to include this provision. At this time, the speaker requested that the House reaffirm their support of the assessment and the corresponding Bylaws change. The results of the vote taken indicated overwhelming support of the prior House action.

ANNOUNCEMENT

The Speaker announced that the Board of Trustees

would convene for its reorganization meeting in the Tecumseh Room immediately following the adjournment of the House of Delegates.

ADJOURNMENT

It was moved and seconded that the House of Delegates be adjourned. The House was adjourned at 9:45 a.m.

Respectfully submitted,

John B. Lovette, M.D.
Speaker

D. Ernest Witt, M.D.
Vice Speaker

G. Winfield Yarnall, M.D.
Secretary

Lawrence E. Smarr
Assistant Secretary

Appendices

Appendix A

Annual Report

Pennsylvania Medical Political Action Committee

In this Bicentennial Year we have on many occasions heard the phrase, "Two Hundred Years Ago Today." To interpret the phrase a bit differently, I would like to emphasize the word "Today." "Two Hundred Years Ago" our democratic system was established by a group of political activists which included physicians. "Today" is the important word in this phrase, because today we are challenged more than ever to uphold this great American heritage. 1976 is a major election year, since we will be electing a president and vice president, 50 U. S. Senators, 435 Congressmen, and, of course, members of our State Legislature—25 state senators and 203 state representatives. We experienced many political surprises this past year—surprises that have baffled even the political experts. The primary election results demonstrate the danger of voter apathy and the power of organized forces to elect candidates.

Your Pennsylvania Medical Political Action Committee recognizes the importance of political involvement within the medical community. Since February, members of the PaMPAC Board and staff have been traveling around the state presenting PaMPAC's multimedia program. This show drives home the importance of organized giving and personal involvement. The response to this program has been most rewarding. Physician audiences gained new political awareness because of the show's informative content.

Contributions to candidates through political action committees are fast becoming the major source of financing for both major political parties. The new federal and state laws actually benefit the political action committees,

since the individual is more restricted in what he or she can financially give to a candidate. The trend to forming political action committees is growing—in fact, the Federal Election Commission has reported the proliferation of 110 new political action committees since January, 1976.

PaMPAC today will be involved in more campaigns than ever before. The political demand today is much greater because the Pennsylvania Medical Society's legislative programs have become so complex. With issues such as medical malpractice, comprehensive health planning, and many others, Medicine's voice must be heard much louder in the halls of the Congress and the Legislature.

Today, in order for our voice to be heard, we need more membership. PaMPAC has remained at approximately the same level—30 percent of PMS membership, for the past 10 years. How does the Pennsylvania Medical Political Action Committee compare to the rest of the state medical political action committees? There are 38 states ahead of their all-time high in pac memberships. Consequently AMPAC has broken its membership records for the eighth straight year.

Today, PaMPAC recognizes that the growth of pac memberships is due to leadership—leadership such as this House of Delegates. We urge you to all become members, and, to go one further, consider becoming a sustaining member. AMPAC will be presenting an award to each state pac in which all the AMA delegates, alternate delegates, presidents, and presidents elect are sustaining members. While it is nice to get an award from our national organization, the more important award is medicine's involvement in the electoral process.

Today, we talk of voter apathy and political scandals. We question the intent of our governmental officials. However, more important than this questioning is the creation of an atmosphere of good government by your participation in democracy.

On behalf of the PaMPAC Board of Directors, I thank this House for your continued support.

Appendix B

Remarks

**Robert N. Moyers, M.D., Vice President
Pennsylvania Medical Cooperative**

I have a fantastic story to bring to you today. It is almost a Cinderella story. It is about an organization started for physicians, by physicians, on, what is considered in the business world, a "shoestring". It is a story of phenomenal growth. My story is about the Pennsylvania Medical Cooperative . . . the only such organization in the world. In less than a year, the co-op has grown from weekly sales of only \$3,000, to sales now in excess of \$12,000 per week . . . quadruple growth, if you will!

Outstanding sales growth is only part of the picture. Product growth has been phenomenal also. When the doors were opened for business, the co-op offered only 250 items. We are now over the 1,500 mark and should top 2,000 items by the beginning of 1977. This is all in our goal of becoming a full-service co-op in the shortest possible time.

I have been involved personally in the Cooperative since the idea developed in the Council on Professional Relations and Services several years ago. It has indeed been an exciting experience to see this project evolve to its present state . . . a state of "near success." I am gratified by the foresight of the members of this body that made it all possible. Doctors need an economical way to purchase the supplies required to run an efficient office and the Pennsylvania Medical Society filled that need.

As fantastic as the growth of the Cooperative has been, we did not reach our projected million-dollar business in the first year. Experience has shown us that we were a bit too optimistic in our projection. Still, that should not detract from what the co-op has accomplished and what it will accomplish in the future.

The Pennsylvania Medical Cooperative was established as a member benefit for physicians belonging to the Pennsylvania Medical Society and also to save those members who joined the Cooperative money on the purchase of office and medical supplies. We are meeting those objectives.

The Pennsylvania Medical Cooperative is helping to attract new members into the Pennsylvania Medical Society. We have documented cases where physicians joined the Society so they could take advantage of the co-op. And, as the popularity of the co-op rises, so should PMS membership.

One other point is the amount of member participation in the co-op. The co-op ranks second only to malpractice insurance in PMS member participation. It has a paid membership of 1,800 and group participation boosts that to more than 2,500 PMS members! With that kind of PMS participation, the Pennsylvania Medical Cooperative cannot be ignored.

Savings to members have been phenomenal. Nearly \$100,000 in savings to members has been realized through only 11 months of operation. And we have only

begun to scratch the surface. Let me use the words of satisfied members to tell you the story:

One surgeon wrote that he saved \$700 on the purchase of an exam table. In another case, a family physician was pleased to learn that by using the co-op rather than an outside firm, he saved more than his \$200 membership fee with his very first order. He thought that was fantastic. An internist wrote, "I saved more than my \$200 membership fee in the first few months of purchasing through the Pennsylvania Medical Cooperative." He concluded by saying that "all future savings will be gravy."

The Pennsylvania Medical Society saw a member need and filled it with the formation of the Pennsylvania Medical Cooperative. We can be thankful for that foresight. Now the Cooperative is at a crossroad. One road leads to mediocrity, the other to rapid expansion to compete more effectively against competitors. We really have no choice. We must grow! But that choice requires support from the parent organization which made it all possible.

You have before you numerous reports and resolutions recommending the overturn of a House decision in 1974 not to provide any additional support to the co-op. On behalf of current PMS members of the co-op and for future PMS members, I urge you to give the Pennsylvania Medical Society Board of Trustees and Councilors permission to exercise their judgment as to how the Society can further support this worthy project. Give the co-op more than just a fighting chance for greater success.

Appendix C

Remarks

**Sidney O. Krasnoff, M.D., President
Pennsylvania Medical Care Foundation**

Mr. Speaker, officers, members of the Board, fellow members of the House of Delegates—you have received the 1976 Annual Report of the Pennsylvania Medical Care Foundation and members of the Foundation's Board and I shall be happy to augment, explain, or respond to any questions you may have during the hearing of the Reference Committee on Medical Service B.

I want to take this opportunity to express our gratitude to the Society's Board of Trustees and Councilors for the privilege of participating in the Board's long-range planning session this past July.

Rather than review the Foundation's many activities during the past year, I would like—with your permission—to discuss a facet of our daily lives as physicians which I believe has become a major problem of crisis proportion due to the burdens placed upon us by the invasions of government bureaucracy.

Overshadowed by the continuing crisis of medical liability insurance, the electronic processing of medical data and its control have, like the "dawn" on the road to Mandalay "come up like thunder." They stand before us—a most critical issue.

In 1966, speaking before the American Society of Internal Medicine, I stated that if we, as physicians, were to

survive in a world with this logic, we must adjust our beliefs, behavior, and goals to live with these (machines)—these versatile friends or slaves, as you may choose to call them. We should not allow ourselves to become the victims of—but should be involved in the design and control of this ever progressive methodology. We, as physicians, should realize their potential and not lag behind in adopting methods already so successfully employed by industry and government.

I further admonished that we must plan for a future where, if the difficulty of a medical problem is an engineering one, no competent physician be ignorant of the engineering involved. Paraphrasing the late Norbert Wiener—if the difficulty of a medical problem is engineering in essence, ten (10) physicians ignorant of engineering will get precisely as far as one (1) such ignorant physician and no farther.

And so, ten (10) years later we are exactly no farther along because of either ignorance or disinterest. Meanwhile, the data we generate in our medical practices become lucrative lures to hundreds of organizations throughout the country which have developed electronic data processing capabilities. Nowhere has this critical situation been more explosive than in the competition for the electronic data processing contracts for the PSROs around the nation.

In simplistic terms, this data is generated as a result of a communication between patient and physician—to be used in a peer review of the physician's services; therefore, the control of this communication belongs solely to those who generate and use the data—it belongs to us, the physicians.

How this data is handled may often allow for erosion of control. For instance, a pencil and paper method, locked in an office filing cabinet is rather secure—except perhaps if the Chief Executive orders a henchman to obtain the data for political purposes.

The volumes of data that we are generating however, do not lend themselves to the outmoded pencil and paper approach and so we must turn to sophisticated electronic methods of recording, collating, and mathematically processing this data.

Since time immemorial and by the Oath of Hippocrates, we have coveted the control and confidentiality of the data generated by our professional activity. Whether processed by mallet, chisel and stone, quill, or ballpoint pen and pad, or diodes, cathodes, switches and tapes, there is no need to relinquish this control now.

Whether as the result of the Foundation's hard line negotiations with commercial outfits such as, PAID Prescriptions, federal and state agencies (such as HEW and DPW), other contracts with government intermediaries (Blues, etc.), or because of our recent experience with the various electronic data processing vendors—the Foundation's activity over the past ten (10) months has led me to the firm conclusion that if Pennsylvania physicians are to maintain control of their own data, I believe the Pennsylvania Medical Society must immediately face the critical issue raised here.

The Pennsylvania Medical Society should officially address the medical data issue and consider developing the

capability to handle data generated by the professional activities of physicians to best serve the interests and needs of the physicians of the Commonwealth—including the needs demanded by peer review of the necessity, appropriateness, and quality of services which physicians either provide or prescribe. Such a project could also include an assessment of the administrative data needs of the Pennsylvania Medical Society (membership records, mailing lists, inventory system for the Cooperative, record system for the captive insurance company, etc.)

Mr. Speaker, this recommendation is the distillate of a most interesting and challenging ten (10) months of service—aided by the superior guidance of the Foundation staff, Dr. Matthew Marshall, and the officers and Board of the Pennsylvania Medical Care Foundation, to whom I am deeply grateful.

Appendix D

Supplemental Report A Committee on Medical Benevolence

The Committee on Medical Benevolence reviewed figures for the past two years, in which the dues allocation was \$2.00 per Active Member. In each of these years the Medical Benevolence Fund had a slight excess of funds available over disbursements. Projections for 1977 show that with a \$1.00 allocation, the Fund will disburse approximately \$5,000 more than it receives, the balance coming from the Fund's principal. With a \$2.00 allocation, the Fund will have an excess over disbursements of approximately \$5,000. In order to balance the slight excess of the past two years, the Committee recommends that \$1.00 be allocated to the Fund for every Active Member.

Respectfully submitted,
Leroy A. Gehris, M.D.
Ralph K. Shields, M.D.
G. Winfield Yarnall, M.D.
Cyrus B. Sleese, M.D., Chairman

Appendix E

Supplemental Report B Board of Trustees and Councilors

During the special meeting of the House of Delegates of the Pennsylvania Medical Society held on July 11, 1976, the Board of Directors of the Pennsylvania Medical Society Liability Insurance Company was requested to make recommendations to the Board of Trustees of the Pennsylvania Medical Society with respect to appropriate methods to raise policyholders' surplus and to determine the amount of any policyholders' surplus required. The Board of Directors met on July 28, 1976, and this subject was discussed in detail. It is estimated that if the Company

begins writing insurance utilizing the present Argonaut book of business, which amounts to approximately \$18 million annual premium, the amount of initial surplus needed will be a minimum of \$6 million.

Legal counsel discussed with the Board of Directors of the Company and Board of Trustees of the Society the various ways to raise policyholders' surplus.

Counsel indicated that the methods to raise capital should be categorized by the federal income tax treatment of funds received by the Company. A pure premium surcharge probably would be treated as revenue to the Company and since all of the revenue would be accounted for as policyholders' surplus, the surcharge would be taxable to the Company at the rate of 48 percent. Therefore, since the Company would be paying out half of the monies received, the surcharge would have to be twice the amount of other methods of raising policyholders' surplus. Counsel stated that a policyholders' surcharge would be deductible by the physician. He said as a general rule of thumb whatever would be deductible to the physician would be taxable to the Company.

Methods of raising policyholders' surplus which would not be recognized as income for federal income tax purposes would be the sale of subordinated capital notes, the sale of equity securities, and an assessment by the Pennsylvania Medical Society which would be contributed to the Company.

Counsel stated that with respect to the sale of subordinated capital notes, such notes could not be redeemed without the prior consent of the Pennsylvania Insurance Commissioner. Further, it would be unlikely that the Company would be in a financial position to pay off the notes and, therefore, the most likely tax consequences to the investor would be the write-off of a long term capital loss. In addition, such notes must be registered with the Pennsylvania Securities Commission. Registration would involve both delay and expense. With respect to the sale of equity securities, the Pennsylvania Insurance Code requires that every share of capital stock have one vote. Accordingly, there would be a dilution of the control by the Pennsylvania Medical Society. Further, this vehicle would also have the disadvantage of the expenses and delays attendant to the registration of securities. Finally, the Pennsylvania Medical Society could assess some or all of its members and contribute the proceeds of the assessment to the capital of the Company. Counsel indicated that when the Society receives the proceeds of the assessment earmarked for contribution to the Company, the (501) (c) (6) tax status of Pennsylvania Medical Society would not be jeopardized. Further, when the funds are contributed to the Company they would not be recognized as income for purposes of federal income tax. Counsel stated that no opinion could be expressed with respect to the deductibility to the physician of an assessment levied by the Pennsylvania Medical Society since there is no precedent upon which such an opinion could be based.

Counsel also reviewed certain principles of statutory accounting and stressed that premium of an insurance company committed to reserves is not taxable and that policyholders' surplus is the amount by which assets exceed reserve and other liabilities. Further, he stated that

classically insurance regulatory authorities strive to have sufficient reserves to fund obligations to policyholders and third party claimants, whereas the IRS has a tendency to attack reserves in order to increase taxes payable.

The Board of Directors of PMSLIC has recommended to the Society Board of Trustees that the Society impose a uniform assessment of its members in the amount of \$500 and impose an additional \$500 to those physicians who apply to the Company for professional liability insurance. The Board of Trustees generally approves of this method of providing the initial policyholders' surplus. The Board is of the opinion that it is incumbent upon all members of the Society to share in the expense of this venture, as it directly or indirectly affects all physicians practicing within the state. Accordingly, the Board of Trustees recommends that the following resolution be adopted.

WHEREAS, This Society has sponsored a program of professional liability insurance underwritten by Argonaut Insurance Company (Argonaut) available to members of this Society pursuant to the terms and conditions of an agreement among Argonaut, this Society and Frank B. Hall of Pennsylvania, Inc., effective as of June 1, 1971 (the Agreement); and

WHEREAS, There are presently issues and controversy between this Society and Argonaut, some of which are pending in state and federal courts; and

WHEREAS, Argonaut has expressed a desire to terminate the aforesaid Agreement and has purportedly repudiated such Agreement; and

WHEREAS, The Society has organized Pennsylvania Medical Society Liability Insurance Company (the "Company") for the purpose of succeeding to Argonaut under the Society sponsored professional liability insurance program and not to compete with Argonaut; and

WHEREAS, The Board of Trustees and Councilors has recommended that this House of Delegates authorize, levy and impose a combination of a uniform assessment of all members of this Society and an additional selective assessment to those members of this Society who apply to the Company for insurance; and

On motion, seconded, and carried it was:

RESOLVED, That there is hereby levied, assessed, and imposed a mandatory assessment upon all members of this Society in the amount of Five Hundred Dollars (\$500.00) per member, payable only upon authorization of and in accordance with terms as to payment to be adopted by resolution of the Board of Trustees and Councilors, enforceable by termination of membership in this Society upon non-payment when due; and

RESOLVED FURTHER, That any member of this Society who terminates such membership and again applies to become a member of this Society shall be fully liable for the assessment imposed hereby; provided, however, that the penalty of termination of membership for non-payment of this assessment may, upon recommendation of such members' component county medical society and upon review and approval by the Board of Trustees and Councilors of the Society, be waived upon showing special circumstances such as, and without limitation, cessation of practice by reason of health, total removal of practice from Pennsylvania, etc.; and

RESOLVED FURTHER, That there is hereby levied, assessed, and imposed an additional mandatory assessment in the amount of Five Hundred Dollars (\$500.00) per member payable only upon authorization of, and in accordance with, terms as to payment to be adopted by resolution of the Board of Trustees and Councilors by members of this Society who apply to the Company for insurance; provided, however, that upon rejection of an application for insurance to the Company by a member of this Society, the selective assessment levied upon applicants for insurance shall be returned to the applicant-member; and

RESOLVED FURTHER, That appropriate officers of this Society be and they hereby are authorized to take any and all necessary and proper acts to give effect to this resolution and to contribute on behalf of this Society to the Company as policyholders' surplus any and all sums raised pursuant to the mandatory uniform and selective assessments imposed hereby.

In order to implement the foregoing resolution Chapter IX, Section 1 of the Bylaws must be amended to permit an all-member assessment for use in funding the Pennsylvania Medical Society Liability Insurance Company.

Resolution to Amend Bylaws

RESOLVED, That Chapter IX, Section 1 of the Bylaws of this Society be and it is hereby amended and restated in its entirety to provide as follows:

SECTION 1. Assessments. Each Active, Senior Active, Intern, and Resident Member of this Society shall, through his Component Society, pay such member's annual assessment to the Executive Vice President prior to March 1, and pay any special assessments authorized by the House of Delegates directly to the Executive Vice President prior to the due date of any special assessment. New members shall pay annual assessments in the same manner at the time of their certification or application for membership.

RESOLVED, That Chapter IX, Section 2 of the Bylaws of this Society be and it is hereby amended by striking the first sentence of such section and inserting in lieu thereof the following sentence:

A member whose annual assessment or special assessment is not paid at the time mentioned in Section 1 above shall be delinquent and shall not be in good standing in this Society.

Respectfully submitted,
George A. Rowland, M.D.
Chairman

Minority Opinion to Supplemental Report B

I agree entirely that this report reflects the actions of the Board of Trustees taken at the August 11, 1976, meeting. I also agree with the content of this report with the exception of the words "incumbent upon all members" found in the last paragraph of the report. I do not believe that it is the duty of all members of the Society to *financially* support the foundation of the Pennsylvania Medical Society Liability Insurance Company. The assessment should

apply only to those who participate in and benefit from the captive insurance company.

Respectfully submitted,
Orlo G. McCoy, M.D.
Trustee and Councilor

(Secretary's Note: At the Opening Session of the House, William C. Ryan, M.D., Trustee and Councilor of the 11th District, requested of the Speaker that his name be included as a signer of the above minority report. The request was granted.)

Appendix F

Supplemental Report C Board of Trustees and Councilors

At its August 1976 meeting, the Board of Trustees took action on a number of items which are of interest to the House of Delegates but which require no specific House action. The Board of Trustees takes this opportunity to inform the House of Delegates of some of the major actions taken at that meeting. Items which require House action will be in additional supplemental reports. The actions are:

1. Accepted the recommendation from legal counsel as to a proposed bargaining position in an attempt to settle the dispute with the Argonaut Insurance Company. The Board then approved a recommendation to reject Argonaut's counterproposal.

2. Determined to seek injunctive relief to require Argonaut to continue to perform under the 1971 PMS-Argonaut contract.

3. Determined to make the Executive Committee the body that may make additional determinations in the future with respect to the Argonaut negotiations.

4. Approved the recommendation of the Pennsylvania Medical Care Foundation's Board of Directors that the PMS Board of Trustees request the Commission on Accreditation to investigate and explain the apparent inconsistencies, at both state and national levels, in classifying credits for continuing medical education programs.

5. Approved the recommendation that we oppose the Kennedy Health Manpower Bill and sent communications to our Representatives in Washington, D.C., stating this.

6. Approved the recommendation that an ad hoc committee on the impaired physician be appointed by the president.

7. Approved the recommendation of the Council on Education and Science that the Board reaffirm a major goal of PMS to promote by all possible means the highest quality of medical care to the people of Pennsylvania.

8. Approved a recommendation from the Council on Education and Science that there should be established in Pennsylvania a medical education council with appropriate representation from the medical community to coor-

dinate undergraduate, graduate, and continuing education efforts.

9. Rejected the recommendation of the Council on Education and Science that the \$50 arbitration panel surcharge for residents still in training be removed.

10. Approved the request of the Council on Medical Service that the Board reconstitute the Commission on Health Planning so that one physician from each designated HSA in the state be appointed. In addition, the Board approved the recommendation of the Finance Committee that the Commission on Health Planning be granted permission to hold several regional HSA roundup meetings.

11. Determined to look into a proposal that PMS co-sponsor with the AMA a negotiation seminar and obtain more information for report back to the next Board meeting.

12. Referred to the Council on Professional Relations and Services for development of the provision of staff services for all specialty societies. The Interspecialty Committee also is to be informed of this and be asked to give input to the Council on Professional Relations and Services.

13. Referred to the Communications Division the proposal of using surveys of member and non-member physicians to guide Society policy in such areas as membership benefits, appeals to non-members, etc.

14. Referred the proposed state guidelines for licensing of hospitals to the Council on Medical Service for review.

Respectfully submitted,
George A. Rowland, M.D.
Chairman

Appendix G

Supplemental Report D

Council on Governmental Relations

At this writing, the Legislature is in recess until September 20, 1976. At that time they will return to Harrisburg for several legislative weeks to "clean up" calendars, and to perhaps act on additional legislation. There is a recess of the Legislature planned several weeks in advance of the General Election to be held on November 2, and of course they must adjourn by law no later than November 30—so you can see how little time is left in this their 160th regular session. Consequently, this report cannot be considered the final history of medical legislation for the legislative years 1975-76, but it is probably at least 90 percent final.

Below are listed 29 categories of bills in which the Pennsylvania Medical Society has had an active interest during the 1975-76 session. It may appear, from reading Society publications over the last two years that the Council's and the Society's officers' activities were almost entirely centered on the medical malpractice issues, but it is obvious from a reading of this report that many other legislative issues, in addition to malpractice, were addressed.

Acupuncture—H-834. The bill would have given the State Board of Medical Education and Licensure the authority to promulgate rules and regulations concerning the use of acupuncture. This bill remained in committee when legislative urgency was lost following an official Attorney General's opinions being handed down giving physicians, dentists, podiatrists and veterinarians exclusive use of acupuncture and specifically denying optometrists and chiropractors its use.

Audiologists—S-1344 and S-1345. These bills would create a state board to license audiologists and speech pathologists. The measures are opposed by the Pennsylvania Academy of Ophthalmology and Otolaryngology and continue to remain in Senate committee.

Anatomical Gifts—H-1817. This bill is the voluminous codification of the Pennsylvania Motor Vehicle Code. Included in its provisions is a stipulation that a driver may affix his Anatomical Donor Card to his driver's license. The provision has been pushed vigorously by the Pennsylvania Medical Society's Auxiliary, and has since become law, and may be cited as Act 81 of 1976.

Ambulances—S-46 and H-728. These bills are similar versions of the State Society's efforts in cooperation with the State Department of Health and other agencies to regulate and qualitatively upgrade the State's volunteer ambulance corps. Each bill has been passed by its originating chamber. Most recently the House defeated S-46; however, it has been resurrected and replaced on the House calendar where attempts will be made to have it passed finally when the Legislature returns.

Battered Children—S-25. The long-considered measure to more effectively protect children from abuse had the backing of many supporters, including the Auxiliary to the Pennsylvania Medical Society. It was passed finally in November of 1975, and may be cited as Act 124 of 1975.

Chiropractors—H-1044 and H-1883. H-1044 would make chiropractic services available under the Workmen's Compensation program. It passed the House and is currently tabled in the Senate Labor Committee. H-1883 would place chiropractic services under the Blue Shield Plan. The bill was once defeated in the Senate by a vote of 28 to 18; however, it was moved to be reconsidered and is currently in the Senate State Government Committee where attempts will be made by the chiropractors, following the recess, to bring it back to the floor.

Comprehensive Health Planning—S-10, H-853, and H-2293. These are all similar versions of the Administration's "Comprehensive Health Planning" bills; among other things, they require most State medical facilities to obtain "certificate of need" permits before expansion, as well as require a multitude of reports, accounting, etc., from hospitals, in-hospital practitioners, etc. None of these bills has passed its originating chamber, and, in all probability, will not go through the remainder of this year.

Conflict of Interest—S-169. The bill makes it a misdemeanor for a person to sit on a hospital board if he has a financial interest through the sale of goods or services to that hospital. This measure passed the Senate and has remained in the House Judiciary Committee since April 1975.

Child Health—S-117 through S-121. All of these measures impact on the health of infants and have been recommended in some instances by pediatric groups. Among other things, they would require marriage license applicants to be examined for immunity to rubella, require premarital serologic testing for carriers of other genetic diseases, require health insurance policies to provide coverage for newborn children, and set up regional newborn special care centers throughout the State. S-119, to provide for serological testing to identify carriers of certain genetic diseases, has passed the Senate. S-120, the bill requiring insurance policies to cover newborns, has become law as Act 81 of 1975. S-121, creation of newborn centers, has passed the Senate and is currently before the House Committee on Health and Welfare. The current version of this bill limits the number of centers to eight for the State.

Death—H-363 and H-2310. H-363 would provide a statutory definition of death. The Society has historically opposed such a definition's being written into law and so testified before the House Judiciary Committee where the bill remains. H-2310 is the so-called "living will" which would permit persons to signify before the onset of illness that they did not want their life prolonged through heroic measures. This bill remains in the House Judiciary Committee.

Disease Reporting—H-1434. The bill would amend the "Disease Prevention and Control Law of 1955" to include as reportable diseases malignant neoplasms and cardiovascular diseases. This bill continues to reside in the House Committee on Health and Welfare.

Emergency Medical Systems—H-1603. The measure would permit the Commonwealth to encourage, through loans and technical help, the development of comprehensive area emergency medical service systems. This measure complements S-46 and H-728, the measures to provide quality control in the system that is to evolve.

Generic Prescriptions—H-473. The bill would permit pharmacists to fill prescriptions generically if the patient requests it and the physician permits it on the prescription blank. This bill has passed the House and is before the Public Health and Welfare Committee in the Senate. The Society has no objection to it as long as the doctor has the veto power over the disposition of the prescription. Language presently in the bill gives the physician the option.

Hearing Aids—H-1880. The proposal has been in the process of development through the last several years. It is designed to regulate persons who sell hearing aids. The

Academy of Ophthalmology and Otolaryngology has cooperated in its design and follows the bill closely.

Information, Medical and Personal—H-11. This is the so-called "Fair Information Practices Act" and attempts to tighten up the amount of medical, personal, financial, etc., information available to outside sources from computer banks, etc. The bill remains in the House Judiciary Committee where members are having a great deal of difficulty in its final design. The Society continues to support the concept of confidentiality and watches this very carefully.

Immunization Programs, Legal Protection—H-2354. This measure amends the act giving physicians and nurses legal protection when participating in State-approved mass immunization programs not for profit. The bill adds "state, county and local medical societies" in the protection clause. This measure has passed both houses and has been signed by the Governor, making it Act 187 of 1976.

Laboratories, Physicians' Offices Exemption—S-1304. This is the measure caused to be introduced by the Society to reinstate in the "Clinical Laboratory Act" the exemption for a physician's office laboratory operated solely for the physician's own patients. This bill, at the present time, is in the Senate's Committee on Public Health and Welfare.

Medical Assistance, a Study of—H-Res. 131. The House passed H-Res. 131, which requires the House Committee on Health and Welfare to investigate the Department of Public Welfare's medicaid reimbursement system. The Society was especially interested in having this resolution pass and the study take place. The House Health and Welfare Committee has conducted hearings at which the State Society has testified.

Medical Assistance, Reform of Payment Methods—H-694. This bill is the so-called "Welfare Reform" that was the result of many hearings, and mostly the effort of Senator Richard Snyder of Lancaster County. One of the provisions in the bill is of extreme interest to the Society in that it would permit the Department of Public Welfare to prepay or contract for insurance coverage for Medical Assistance recipients. This bill has passed both houses and has been signed by the Governor as Act 202 of 1976.

Medical Assistance, Deficiency Appropriation—H-78. The Society, together with the Hospital Association of Pennsylvania, assisted in getting through the Legislature rather promptly a \$31 million deficiency appropriation which otherwise would have caused the non-payment of hospitals and physicians for Medical Assistance services.

Medical Education—H-545 and H-546. These are the "Pennsylvania Medical Education Council" and "Pennsylvania Medical District" bills. Both of these have passed the House and are currently before Senate Committees where they are expected not to surface for the remainder of the year.

Medical Licensure, Cost—H-2422. This measure is a bill that was introduced by the Administration to increase the biennial costs of all professional and occupational licenses. The bill stipulates a \$50 biennial cost for the renewal of a medical license. The House has once defeated this bill; however, it is to be reconsidered and we can expect an additional vote when the Legislature returns. With the current statutory provision that the State Board of Medical Education and Licensure retains all of its fees, we stand not to be as hurt as are other licensed groups.

Medical Malpractice—H-805, H-1367, and H-2063. We are sure you will remember all of these numbers—those of you who followed the legislative medical malpractice saga. H-805, of course, was the Society's offering to the Legislature. Many of the ingredients in it will still be pursued by the Society. H-1367, with amendments of course, became Act 111, and most recently, H-2063 was passed and signed by the Governor and amends Act 111 in several interesting areas, i.e., to permit self-insurance by physicians, to make the jurisdiction of panels exclusive, etc. The Council and the Society will, of course, continue vigorous activity in this area.

Medical Schools, Physicians' Offices Locations—H-251. The measure would prohibit private physicians from having office space in medical schools. This measure remains in the House Committee on Professional Licensure.

Medical Students, Foreign Trained—H-1976. The measure would accommodate the so-called "Fifth Pathway Program" to accommodate American-born, foreign-trained students returning for clinical work in Pennsylvania medical schools. The Society testified in favor of this. It has passed the House and is currently before the Senate Committee on Education.

Mental Health, Common Commitment—S-1025. This is the so-called "Mental Health Procedures Act" which has been in the process of development over the last several years. The Pennsylvania Psychiatric Society has worked with Senator Coppersmith, the bill's prime sponsor, in many of the ingredients. The Society, however, at the last minute, decided to oppose the legislation when amendments were added in the House to give psychologists equal status with psychiatrists under certain circumstances. The bill finally passed and was sent to the Governor, who signed it on July 9, 1976, making it Act 143.

Mental Health, Heads of Programs—H-45. This bill would amend the "Mental Health and Mental Retardation Act of 1966" to reduce the requirement that heads of mental health programs in institutions must be physicians. The Society was successful in getting language which would require the Department of Public Welfare to look for a physician first before offering it to a layperson. It passed and may be cited as Act 46 of 1975.

Physicians' Assistants—S-306 and H-1643. Both of these bills would have the State Board of Medical Education and Licensure regulate the practice and training of physicians' assistants. S-306 has passed the Senate and is

currently before the House Committee on Professional Licensure where it is being "put upon" by nurses, optometrists and others. We are making last-ditch efforts to have it released from committee and voted by the House prior to adjournment.

T.V. Picture Tubes—H-449. The bill which was approved for introduction by our House of Delegates, requiring the neutralization of TV picture tubes prior to their being discarded; this has passed both the House and Senate, was approved by the Governor, and may be cited as Act 74 of 1976.

Respectfully submitted,
R. William Alexander, M.D.
Leonard Bachman, M.D.
Robert J. Carroll, M.D.
Paul A. Cox, M.D.
Herbert Fellerman, M.D.
H. Keith Fischer, M.D.
Charles A. Heisterkamp, III, M.D.
J. Preston Hoyle, M.D.
Lawrence J. Mellon, Jr., M.D.
Bernard B. Zamostien, M.D.
Michael P. Levis, M.D., Vice-Chairman
Donald E. Harrop, M.D., Chairman
David. W. Clare, M.D., Board Representative

Appendix H

Supplemental Report E Committee to Study Physicians' Unions

The Committee to Study Physicians' Unions met at the time of the 1976 Officers' Conference to discuss the current need for and possibility of the formation of a physicians' union in Pennsylvania. The committee believes that the greatest governmental threat to individual physicians stems not from elected political officials, but from the bureaucratic organizations charged with effecting the policies determined by the executive and legislative branches of government. The Pennsylvania Medical Society and the component county medical societies have provided effective administrative and lobbying methods for influencing the legislative process. However, organized medicine has not addressed the need for interface with the lumbering and ever growing federal and state bureaucracies, which through their administrative and regulatory functions are beginning to hold an ever tightening rein on the profession of medicine. A need also exists for organized physicians to have a strong negotiating arm when dealing with hospitals, insurance companies and other organized parties.

Your committee feels that the Pennsylvania Medical Society should further entertain the concept of organized bargaining with the bureaucracy and others. However, we feel it would be inappropriate for PMS to openly conduct union-like activities, and believe the formation of a physi-

physicians' union is a possible method for providing the necessary interface.

Respectfully submitted,
Kenneth L. Cooper, M.D.
Chairman

Appendix I

Supplemental Report F Board of Trustees and Councilors

This report is an attempt to update several sections of the main report of the Trustees and Councilors which is found beginning on page 14 of the Official Reports Book.

Resolutions of the 1975 House of Delegates: *75-3 Abortions* (original report p. 14). As stated in the original report, the Pennsylvania Attorney General had been requested to render a clarifying opinion on the status of the law in Pennsylvania as it relates to abortions. It appears that he will delay this until all appeals of the recently passed Abortion Control Act have been settled in court. The question of whether or not public money can be used to pay for abortions still remains. The Pennsylvania Department of Public Welfare is presently paying a portion of the medical expenses. The status of such payments in the future is uncertain. The Board of Trustees will continue to monitor this situation.

Resolution of the 1975 House of Delegates: *75-26 Peer Review* (original report p. 16). The AMA Council on Medical Service reported to the House of Delegates on this resolution at the AMA's annual meeting in Dallas last June. The AMA Council on Medical Service responded to Resolution 29 (C-75) which recommended that physicians participate only in medical review programs sponsored by organizations representing practicing physicians; the Council in its report recommended against adoption of this resolution.

During the reference committee hearing in Dallas, the Pennsylvania Delegation, which introduced the resolution, asked for further review of the matter by the Council and the Council chairman expressed Council's willingness to accept such a change. The reference committee then recommended, and the AMA House of Delegates concurred, that this resolution be referred back to the Council on Medical Service for further study and report.

Resolutions of the 1975 House of Delegates: *75-30, Laboratory Regulations* (original report p. 16; see also p. 22 in section under Legal Actions). Commonwealth Court, because of a tie vote, dismissed the suit filed by the Pennsylvania Medical Society against the Pennsylvania Health Department over clinical laboratory regulations. After reviewing the situation, the Pennsylvania Medical Society appealed the Clinical Laboratory Suit to the Pennsylvania Supreme Court. The original suit, which was filed last November, contends that the regulations exceed the intent of the law. While the appeal is pending, Commonwealth Court has issued an injunction preventing the

health department from enforcing the regulations. The Supreme Court decision is not likely before next year.

Swine Flu Immunization Program (original report p. 23). In the early stages of development, it was believed that the county medical societies would be asked to take the leadership role in the organization of the Swine Flu Immunization Program. This posed some question as to the individual county's legal liability. This problem never materialized as the Pennsylvania Department of Health assumed, under federal guidelines, the primary responsibility for distribution of the vaccine and for the actual immunizations at the mass immunization sites. This afforded protection is a result of effort on the part of PMS.

The liability question as it related to physicians became very clear. Physicians giving the vaccine in their offices are subject to the usual liability, unless they administer the vaccine at no charge. In that case the physician is exempt from all but gross negligence. The physician who participates in a mass immunization program without pay is also immune from liability except in cases of gross negligence. Under the newly passed legislation, county medical societies are also exempt from liability except in cases of gross negligence for participation in the swine flu immunization program.

The Pennsylvania Medical Society is working closely with the Pennsylvania Department of Health on the Swine Flu Immunization Program. Members of the Pennsylvania Medical Society staff are in regular contact with Health Department staff. George A. Rowland, M.D., chairman of the PMS Board of Trustees, serves as vice chairman of the Swine Flu Advisory Board which has been set up to advise Secretary of Health Leonard Bachman, M.D., on the program.

Chiropractic Treatment of Black Lung. The Executive Committee of the Pennsylvania Medical Society determined late in May that PMS would use every available means to block the Department of Health's plans for referrals to chiropractors from the state's eight black lung clinics at the patients' request. A letter to the Governor from PMS President Dr. David S. Masland, along with several phone calls to Secretary of Health Dr. Leonard Bachman, resulted in a moratorium being issued within hours of the plan's announcement. A special meeting of the Governor's Advisory Committee on Pennsylvania Coal Workers' Respiratory Disease Program was held on June 10. The Committee met to discuss Governor Milton J. Shapp's proposal that chiropractors be included in the state's black lung program. Dr. Masland told the Committee that the Society was "unalterably opposed to the use of a state-funded specific disease oriented program including chiropractic as an officially accepted modality of treatment for that disease." He left a seven-page official position with the committee as well as a paper by Edgar L. Dessen, M.D., Hazleton, chairman of the American College of Radiology's Task Force on Pneumoconiosis. The committee, which included ten physicians, determined to make no change in the program and to study the matter further at a later meeting. Dr. Masland said that the Society was prepared to go to court if necessary to block the chiropractors from the black lung program.

As a result of PMS, labor union, and opposition from

various other groups, the Governor apparently has decided not to pursue his plan to have chiropractic treatments as part of the Black Lung Program.

Respectfully submitted,
George A. Rowland, M.D.
Chairman

Appendix J

Supplemental Report G Council on Medical Service

The following report consists of two areas of update since the writing of the Council's Annual Report (Official Reports Book pages 66-74).

Resolution 75-15 (Petition to the Social Security Administration Regarding Notification to Physicians when Medicare Payment is Sent to the Patient).

At the direction of the 1975 House of Delegates, the Council on Medical Service corresponded with Mr. Thomas M. Tierney, director of the Bureau of Health Insurance at HEW, requesting a change in medicare regulations which would include notification to the physician of the amount and date of payment in non-assigned claims.

In the Council's Annual Report, we indicated that a response had been received from the Bureau of Health Insurance. In that response, Mr. Tierney indicated that a physician who does not accept assignment for payment for services rendered to medicare beneficiaries has no direct connection with the program as far as those particular services are concerned, and has established no legal equity in the payment of the claim by medicare. The response further suggests that current regulations do not permit disclosure of information about a beneficiary in a non-assigned claim.

At its August 29, 1976, meeting the Council on Medical Service considered this response and recognized that the Bureau of Health Insurance does not intend to initiate a change in its reimbursement policy that would encourage non-assignment by physicians. In its deliberations, the Council concluded that physicians do have the choice to accept direct payment through assignment and thus, establish legal equity in the payment of the claim by medicare. If they choose not to accept assignment, the contract exists only between the carrier and the beneficiary. The Council believes that a change by the Bureau of Health Insurance to conform with the intent of Resolution 75-15 would increase the overall costs of the medicare program and that, in balance, the benefits derived by physicians would not justify the added costs.

Therefore, the Council on Medical Service does not believe that the Pennsylvania Medical Society should pursue this matter further.

Resolution 75-5 (Department of Public Welfare Payment).

In the annual report, the Council indicated its interest in working toward a legislative remedy to improving the medicaid program in Pennsylvania. We reported on a res-

olution in the Pennsylvania House of Representatives calling for an investigation into the operation and practices of the Department of Public Welfare.

A number of regional hearings have been scheduled by the House Committee on Health and Welfare, the first of which was held in Harrisburg on July 22, 1976. Attached to this Supplemental Report is a copy of the testimony presented at that hearing by Henry H. Fetterman, M.D., chairman of the PMS Council on Medical Service.

As this investigation continues, the Council will take every opportunity to encourage the Legislature to make positive changes in the medicaid program.

Testimony Before the Sub-Committee on Health of the House Committee on Health and Welfare July 22, 1976

Presented by Henry H. Fetterman, M.D.

Subject: Investigation of the Medicaid Reimbursement Program

Mr. Chairman, members of the committee, as a practicing physician and chairman of the Pennsylvania Medical Society's Council on Medical Service, may I thank you for providing the Society with the opportunity to share with you our views concerning the critical state of affairs in the medical assistance reimbursement program.

I am Henry Fetterman, a practicing obstetrician/gynecologist from Allentown, Pennsylvania. As the current chairman of the Society's Council on Medical Service I am acutely aware of the concerns of physicians regarding what is commonly referred to as the crisis situation in the medicaid program. As you are aware, health costs in the United States today now consume 8.1 percent of the gross national product. It is estimated that 40 billion dollars will be spent on the federal government's medicare/medicaid programs in 1977. With the realization that these trends cannot continue unabated, physicians in Pennsylvania share your desire to investigate ways to reduce medicaid costs while providing quality health care to medical assistance patients.

Since the inception of the medicaid program in 1965, the Pennsylvania Medical Society has attempted to work with the Department of Public Welfare to implement an effective program. In April of 1967 the Medical Society prepared a position paper dealing with the medical assistance program in Pennsylvania. Many of the issues raised at that time have yet to be resolved. We have a long record of negotiation with the department to correct inadequacies that we have identified in the program. In 1968 we were successful in getting DPW to allow Pennsylvania Blue Shield to be the intermediary responsible for payment for services by in-hospital based physicians. As recently as last spring, the Society requested that the word "vendor" on DPW transmittal forms be eliminated and be recognized as an inappropriate term to indicate physician services. Secretary Beal gave his assurances that in future revisions of the invoice transmittal the word "vendor" would be eliminated. Recognizing that we have had some small successes in our dealings with the department, we must admit that on many other occasions we have met with a deaf ear and we continue to feel frustrated in our

attempts to alter the current state of affairs.

The Society is truly encouraged by the emphasis this committee now places on this issue and we believe that it is extremely important that corrective legislation result from your investigation. The appropriation of 32 million dollars, which is the anticipated deficit for the 1975-76 fiscal year budget, can be considered as only a stop-gap measure. True and lasting remedies for the problems that plague the medicaid program must be established now. "Crisis intervention" at the end of each fiscal year would seem an inappropriate solution to an ever recurring problem. Pennsylvania physicians are not unaware of the actions by their colleagues in other states where suits, paper strikes, and work stoppages have been employed to bring about changes in their medicaid programs. While such activities have been seriously discussed in Pennsylvania, you should be aware that organized medicine in this state has consistently discouraged such actions as being inimical to proper patient care. It is our strong feeling that a legislative remedy is the only appropriate way to resolve the problem.

At this time I would like to identify for you several areas of concern that the Society feels most strongly about. I would be less than honest if I stated that reimbursement for physicians' services was not a high priority issue. The Medical Society has repeatedly asked that customary charges be established for physicians' payments. For example, the current payment of \$6.00 per office visit is grossly inadequate. This low payment, coupled with the excessive paperwork and long delay in payment will continue to discourage physicians from participating in the program. Patients will be forced to turn to hospital emergency rooms and outpatient clinics, whose costs are staggering in comparison with the cost in the physician's office. Also, this situation forces a burdensome patient load on a few willing physicians who then are often accused of abusing the system because of the high volume of patients that they see in their offices. With federal guidelines stressing the importance of developing less costly modes of health care delivery, the posture of the Department of Public Welfare would certainly appear to be counter-productive. Inadequate reimbursement for outpatient hospital services as well as services in the physician's office has undoubtedly contributed to the continued lack of ambulatory care services in many of the urban areas having a high medical assistance patient load. The Medical Society fully recognizes that the remedy to this problem may require an additional expenditure of dollars if reimbursement is to adequately cover ambulatory health care services in hospital outpatient facilities as well as the physicians' offices. However, you must realize that the medical assistance program—as currently administered—encourages hospital admission in view of the fact that many conditions are reimbursable only in the hospital setting. We believe that savings can be quickly realized by paying reasonable fees for all appropriate and necessary services rendered in physicians' offices and hospital outpatient departments in lieu of care in the acute hospital setting.

The second major concern to physicians has been the current administrative mechanism for payment. The med-

ical assistance program has the dubious honor of being the slowest third party payor in the State of Pennsylvania. It is estimated that process time is not a matter of weeks, but months. This time lapse is considered twice the time that is required for Blue Cross, medicare, and commercial carriers. The Pennsylvania Medical Society has urged the Department of Public Welfare to contract with Pennsylvania Blue Shield or other carrier to serve as fiscal administrator of that portion of the program dealing with physicians' services. The Society has been convinced for many years that Blue Shield is in a superior position to maintain appropriate utilization control and to assure the provision of high quality medical care and the expeditious payment for services by physicians. We urge this committee to give high priority to this recommendation by requesting the legislature to enact legislation allowing the medicaid intermediary to process checks for payment in the same manner that the fiscal intermediary handles the medicare program.

We are in an era of double digit inflation and indications are that the trend will continue for some time into the future. Physicians experience the same pinch as everyone else in meeting everyday expenses with the added burden of paying professional liability insurance premiums that have become so high that some physicians have had to leave the practice of medicine. These costs *must* be passed on to patients—there is no other way for a physician to maintain his practice. The slice of the medicaid dollar pie which is earmarked for physician care is shrinking. Granted, the payout has not decreased, but as hospitals and other facilities are paid on a reasonable cost or adjusted per diem basis, the fixed inadequate reimbursement to physicians represents a reduction in light of their increased costs and the increased total payout under medicaid.

Since 1972 the Society has been concerned about in-hospital utilization review. Considerable time and effort have been expended by the Society and the Pennsylvania Medical Care Foundation to design and implement a physician-sponsored hospital utilization review program that is consistent with the objectives of the Professional Standards Review Organization (PSRO) for the State of Pennsylvania as authorized by the U.S. Congress. We feel that the committee should be aware that the implementation of the utilization review requirements of the PSRO program has met with many roadblocks. We feel that these have resulted from a lack of cooperation with the Department of Public Welfare. An effective utilization review and quality appraisal project in each hospital will enhance and augment any cost containment program. It is the desire of the Medical Society that the Department of Public Welfare be truly committed to the development of the PSRO program and that it supplement the PSRO requirements for its Pre-Discharge Utilization Review (PDUR) program. The Society feels very strongly that the requirements for utilization review that are imposed by the Professional Standards Review Organizations will only enhance cost effectiveness and quality of care provided in acute care facilities.

Another concern that the Society has only recently given high priority is the dilemma that faces the long-term

care facility as it relates to the Medicaid program. It is our understanding that reimbursement effective July 1, 1976, for skilled nursing and intermediate care facilities will be on a reasonable cost related basis. This is a commendable approach, but if the problem of availability of long-term care beds is to be solved, then there must be an equity in this approach across the State of Pennsylvania. Experts in the nursing home field suggest that costs related to "debt service" be separated from program and administrative costs if we are to encourage the construction of new facilities in areas of critical need such as the City of Philadelphia. It is our understanding that in the urban area of Philadelphia there has been very little construction of long-term care beds in the past twenty years. It is important that incentives be provided if vital new construction or even participation by some of the newer facilities already built are to be encouraged.

Another concern of the Society relates to an original recommendation made by the Pennsylvania Medical Society in 1967. We feel that this recommendation is still current and appropriate. The 1967 statement recommends that the Department of Health be designated the single state agency for Title XIX and be charged with the responsibilities for supervising the quality and availability of medical care, of establishing utilization and medical audit procedures, the determination of medical fees, and handling of all matters that relate specifically to medical care and the medical profession. The responsibility of the Department of Public Welfare should be limited to the eligibility determination, enrollment, registration, and those functions that require a welfare orientation.

The administration of the Medicaid program by any agency during the coming years will be a mammoth undertaking. Even though the problems are astronomical, and the financial resources to solve these problems are finite, we strongly recommend, as we did in 1967, that the proper orientation should be with the Department of Health. We also feel that there are many services that are presently being administered by DPW that could best be handled on a contractual basis with an outside organization having greater proficiency and expertise in the administration of certain aspects of the program. We recognize that the contractual arrangements between the Department of Public Welfare and the PAID Prescription program are in their infancy and it would be inappropriate for us to claim success for this contractual arrangement at this early stage, but we feel that this is an excellent example of cooperative contractual arrangements that can be established.

In addition to those matters which I have previously discussed, the Medical Society wishes to relate its concerns regarding identification of possible Medicaid over-utilization and fraud. It is our understanding that the Department of Public Welfare, due to a lack of funds for a program to monitor and investigate suspected over-utilization problems has requested the assistance of the Auditor General's Office and they have assumed responsibilities for preliminary review of data that is collected concerning over-utilization problems. The Medical Society recognizes that the full extent of fraud and waste in the Medicaid program is only now coming to light. Of course,

we must reiterate that the mere fact that the Medicaid program pays out a great deal of money in claims to a particular physician does not necessarily mean that this physician is in any way abusing the program. In many instances the willing physician puts in 12 to 14 hours per day and treats hundreds of patients a week because other providers in the area have refused to participate in the Medicaid program. During the past several months the Pennsylvania Medical Society has had discussions with representatives from the Auditor General's Office concerning the subject of Medicaid fraud committed by doctors of medicine and osteopathy, chiropractors, and podiatrists. The Society has made the Auditor General's Office aware that we indeed share their concerns and that we are interested in discussing the applicability of the Society's participation in a review mechanism to identify over-utilization and fraud in the Medicaid program.

The Medical Society recognizes the need for surveillance and audit and encourages the department to recognize that the installation of automated claims processing techniques would enhance their ability to detect problems before they become examples of over-utilization or fraud. We strongly support review mechanisms by professionals and willingly offer our support to the review and investigation of questionable practices by doctors of medicine.

Thank you very much for allowing me to express these concerns. We are ready to assist the committee or the appropriate state agency in any way to improve the delivery of care to recipients of the Medicaid program.

Appendix K

Supplemental Report H Council on Education and Science

Membership CME Standard

The Commission on Accreditation has met to review the status of the continuing medical education requirement for membership in this Society.

As of September 13, 1976, 12,621 members of PMS had to meet the CME membership requirement. We have only 1,119 Active and Senior Active members not qualified as of that date. In the reporting process are approximately 250 applications, thus 869 members have not met their CME requirement. This is less than 7 percent of PMS membership; 93 percent of our membership has completed the standard. A detailed statistical report is outlined at the end of this report.

We are doing the following activities to see if we can qualify all members by the end of the year:

(1) All community hospitals in Pennsylvania have been contacted with a list of physicians who are in their county or adjoining counties who may have staff privileges in their institution. Our question was whether or not, through a hospital requirement, any of these physicians may have completed 150 hours of continuing education. At the same time, we communicated with the county med-

**STATISTICAL REVIEW
CME Membership Requirement
September 13, 1976**

Number of members who must meet standard:	12,621
Number of members not qualified:	1,119
Number of applications in process:	250
Number of members who still must qualify:	869

Method Used by Members to Meet Standard

AMA's Physician's Recognition Award:	7,557	66%
Processed by PMS	335	3%
Pennsylvania Academy of Family Physicians	1,220	11%
Waiver (includes permanent, limited, conditional)	373	4%
New members, Resident or Intern, Associate (requirement delayed until a later date)	1,780	16%

ical societies that this project was underway.

(2) Following the House of Delegates meeting, we plan to send to the county medical societies a list of their member physicians who have not met the educational standard, requesting that they contact them directly to gather such information as:

- (a) whether or not the physician is going to meet the standard;
- (b) whether the application has been sent in;
- (c) whether the physician is retired;
- (d) does he need a waiver application;
- (e) whether the physician needs help filling out the application, etc.

In other words, a status report on every member who has not achieved the standard by October 15, 1976.

(3) The next step will be to send a prewarning letter of suspension to all physicians who have been identified as not meeting the educational standard. It is expected that such a letter will be sent out early in October indicating that if they do not meet the requirement they will be suspended in 1977.

(4) By the first of November a letter will be sent to all physicians who have not met the educational standard indicating that they will be suspended as of January 1, 1977, and lose their rights and privileges for one year unless the House adopts an amendment to Chapter I of the Bylaws as recommended by the Committee on Constitution and Bylaws allowing reinstatement immediately upon satisfying the CME requirement. However, they must continue to pay their dues in the Society. It will be emphasized in the letter that failure to meet the standard does not affect their license to practice medicine in Pennsylvania but only their association with their professional society.

Requalifying Process

We have also begun to develop a system of notifying member physicians that their Physician's Recognition Award has expired and they must reapply. By June 1, 1977, 321 members must requalify. It is our intent to notify these members directly from our office and not use the communication capabilities of the American Medical Association. We believe our control would be better than the AMA's. We'll be able to keep apprised of the status of our membership more exactly through this mechanism. The plan is as follows:

(1) Six months prior to the time of the expiration of his PRA or his alternate acceptable criteria for CME in the Society, we will send out a new application form prepared by a computer which will have already filled in for his use his name, address, ME number and the date of the expiration of his certificate and whether or not he is an AMA member.

(2) All applications will be returned to our office and we in turn will send those who are AMA members on to Chicago for processing so these members can receive the Physician's Recognition Award certificate and retain the remainder in our office for processing. We plan to code into our computer all forms sent to AMA which are in process, thus eliminating the possibility of lost forms and also to keep us apprised of the status of our program on a monthly basis.

(3) If we do not receive a renewal application from a physician by the time that his continuing education award expires, we will send him a reminder form and ask him to complete this and return it to our office.

(4) Once an application has been received in our office, we will send a card indicating that we have received the form and that it is in the system of processing. The card will indicate that unless he hears otherwise from us he can be assured that he has met the educational standard and should continue his CME activities, working toward the next reporting period in three years.

We believe that this system can be done at a reasonable cost and will provide adequate control of the total program by the Society.

As more specialty societies begin adopting standards for membership in their organizations and as specialty boards develop the recertification program, we will have to make modifications in our standard to be sure that we recognize which source the physician is using to meet the CME requirement. This becomes a little confusing and many of the details will have to be worked out at the national level.

The only other group that needs to be addressed is the Associate members who must meet the standard by October 1977. We will make a special effort to communicate with each of these members. There are 664 in that category.

Respectfully submitted,
Gerald L. Andriole, M.D.
Mark Berger, M.D.
William E. DeMuth, Jr., M.D.
Paul W. Dishart, M.D.
Frederick D. Fister, M.D.
William C. Grasley, M.D.
Arthur H. Hayes, Jr., M.D.
Abram M. Hostetter, M.D.
Roland A. Loeb, M.D.
Herbert C. Perlman, M.D.
Jacob Schut, M.D.
Nathan Sussman, M.D.
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Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

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Medical Arts '76 marked by variety

The State Society's educational assembly, Medical Arts '76, held at the Hershey Motor Lodge and Convention Center November 3-5, attracted physicians and other health professionals from throughout the Commonwealth. They attended a wide variety of seminars and meetings, including the first annual meeting of the Pennsylvania Council of Health Professionals, an office management seminar for medical assistants, and a number of specialty society functions.

The Society's Commission on Accreditation, and the Executive Committee of the Council on Ed-

ucation and Science, and the Committee on Medicine, Religion, and Bioethics held business meetings during the three days,

and the latter group sponsored a prayer breakfast for physicians and clergymen during the session.



MEMBERS of the Pennsylvania Psychiatric Society will be billed in January for a \$25 assessment voted at a business meeting held during Medical Arts '76. The funds will be used in the battle against portions of Act 143, the state's new Mental Health Commitment Act.



THE COMMITTEE on Medicine, Religion, and Bioethics held its annual Prayer Breakfast November 4. The audience is shown at the left. Immediately below is Wilbur E. Flannery, M.D., committee chairman, introducing the speaker, William B. Oglesby, Jr., who is shown in the bottom photograph. Dr. Oglesby's topic was "Pastoral Counseling in the Light of New Medical Technology."



FEATURED at the recent fall meeting of the Dauphin County Medical Society was a discussion of the practice of medicine at the time of the American Revolution, presented by Whitfield Bell, Jr., M.D., Philadelphia, librarian of the American Philosophical Society. Reviewing the official program of the meeting are, left to right: Paul Kase, M.D., president of the county society; Thomas Fletcher, M.D., program chairman; Dr. Bell; and R. Edward Steele, M.D., a past president of the county society.



New publication is public health education tool

DEBORAH L. RUSSELL
Editorial Assistant

The Health Robbers, How to Protect Your Money and Your Life, edited by Stephen Barrett, M.D., and Gilda Knight, 340 pages, Charles F. Stickley Company, Philadelphia, 1976. \$10.50.

"Throughout the world, hundreds of thousands of scientists work continuously to determine the boundaries of scientific thought. So if you find someone referred to as a 'scientist ahead of his time,' he is probably a quack."

It is a cynical, although realistic, attitude, and it is the attitude taken by editors Stephen Barrett, M.D., and Gilda Knight in *The Health Robbers, How to Protect Your Money and Your Life*.

The Health Robbers, a collection of essays by prominent health professionals, systematically attacks and dispels the major fraudulent health theories, treatments, and gimmicks currently being used.

"Health science has never had more to offer than it does today. Yet trust in doctors has fallen . . . and quackery is at an all time high," states the introduction to the book. *The Health Robbers* is part of a campaign by the Lehigh Valley Committee Against Health Fraud, Inc., to help counteract the large amounts of misleading health information fed to the public every day.

The editors have long been opponents of fraud in health care. Dr. Barrett is a practicing psychiatrist and has served since 1970 as chairman of the board of directors of the Lehigh Valley Committee Against Health Fraud, Inc. He is an active member of the State Society's Committee on Quackery and has served on the Pennsylvania Health Council's Committee on Health Fraud. Ms. Knight has been an executive as-

sistant for the American Institute of Nutrition since 1965 and is the managing editor of the organization's publication, *Nutrition Notes*.

In the first part of *The Health Robbers*, each chapter discusses a specific area of health fraud in a simple, logical manner, using facts to back up accusations. Background, current practices, and ways to spot the fraud are incorporated into most chapters.

The authors are experienced and knowledgeable in their respective fields: William H. Masters, M.D., director of the Reproductive Biology Research Foundation, writes on phony sex clinics; Sidney L. Arje, M.D., vice president for professional development, and Lois V. Smith, a former program associate for unproven methods, both with the American Cancer Society, write about fraudulent cancer treatments; Mary Bernhardt, secretary of the American Dental Association's Council on Dental Health, writes on the fluoridation controversy. Topics go from the organic food fad, to faith healing, to fraudulent dentistry, to gadgeteers.

Part two of the book is made up of essays on the media, state and federal government, why quackery is so prevalent, why so many people mistrust doctors, and how physicians and patients might be able to communicate better with each other.

In the chapter entitled "Why Quackery Persists," James Harvey Young, Ph.D., professor of history of Emory University, explains, although in a simplified manner, why the general public is growing more suspicious of orthodox medicine:

"Orthodox physicians . . . have a problem because of their power and status. Non-experts feel ill at ease in the presence of an expert.

The patient is upset because he is sick and worried. Perceiving the physician as busy and under pressure, the patient may feel like an intruder. The doctor is often brusque, does not take the time to listen, neglects to explain. His prognosis may be discouraging, his therapy prolonged and unpleasant. He charges a lot, earns more, and lives better than the patient, perhaps causing irritation and envy. Some patients are just plain frightened away from reputable doctors whose rapport falls below that which quacks are able to muster. Even patients who think well of their own doctors may think ill of doctors as a group. The power side of establishment medicine has alienated many people. Organized medicine, they have felt, works for its own economic and political self-interest more than for the common good. Such an image helps quackery. For throughout history, any criticism of the power or the science of orthodox medicine has been pounced upon by the quack, magnified, and loudly trumpeted abroad."

The Health Robbers does not insult the reader; it appeals to him as an intelligent, thinking person. It is not designed to scare the reader, but to make him aware of the facts: that state government can try to regulate health fraud through licensing procedures, and that federal government can try to regulate it through drug and device and advertising laws, but the individual person's own knowledge and reasoning are the best weapons against fraud in the field of health care.

The Health Robbers was published for the Lehigh Valley Committee Against Health Fraud, Inc. Profits from the sale of the book by the committee will be used to combat deception in health care.

County societies join health education effort

The Lackawanna, Luzerne, and Lycoming County Medical Societies, Robert Packer Hospital, and Geisinger Medical Center have joined with television station WVIA, Channel 44, in Scranton, to present a weekly, live health information series for area viewers. A major feature of the series is the opportunity for viewers to telephone medical questions to the various panelist-physicians appearing on the programs.

The 45 minute program, which premiered the first week in November, is shown each Monday evening at 6:15 and is scheduled to run for 30 weeks.

The Monday evening program is part of "Phone 44," a nightly series dealing with a wide range of topics, including public affairs, homemaking, and education. Each evening is devoted to a different theme.

Topics and guests for the Monday evening programs are selected by Channel 44 and representatives from the continuing medical education committees of the Lackawanna, Luzerne, and Lycoming societies, Geisinger

Medical Center, and Robert Packer Hospital. Scheduled for discussion are: diabetes, arthritis, smoking, birth control, weight, alcoholism, heart attacks, cancer, hypertension, and nutrition.

Channel 44 has a special telephone number which viewers may call collect to ask medically related questions—(717) 655-5911. Phones are manned by student nurses who relate the questions to the panelists.



REPRESENTATIVES of the Lackawanna County Medical Society and public television station WVIA, helping to plan segments of "Phone 44" are, seated left to right: Anthony N. Fazio, M.D., co-chairman of the county society continuing medical education committee; Ruth Banks, executive director of the county society; and Paul C. Royce, M.D., director of medical education at the Robert Packer Hospital, Sayre. Standing are: Peter Brewer, Channel 44 director; and Jerry Schumacher, program producer and moderator.

Primary care topic

Johns Hopkins University School of Medicine and Baltimore city hospitals will present a one day symposium on Problems in Primary Care at Baltimore city hospitals Saturday, January 29.

The course is designed to provide continuing education to physicians with interest in primary adult care. Lectures and informal discussion will be utilized to deal with a variety of common adult care problems.

For further information contact the Office of Continuing Education, Room 17, Turner Auditorium, 720 Rutland Ave., Baltimore, MD 21205.

Rising tuition and dwindling sources for financial aid have been and are expected to be the major problems facing many medical students.

Physicians can help solve part of the problem and gain an income tax deduction at the same time by contributing to the State Society Educational and Scientific Trust.

In August the Committee on Aid to Education granted a total of \$186,650 in loans to 146 medical students, according to the recent annual report of the Educational and Scientific Trust. Many more students are in need of financial aid.

Tax deductible contributions may be sent to the Educational and Scientific Trust, Pennsylvania Medical Society, 20 Erford Rd., Lemoyne, PA 17043. An immediate contribution may be deducted from the 1976 income tax.

For more information contact Mr. Alex H. Stewart, executive director of the Trust, at Society Headquarters.

Childhood screening program at halfway mark

Under Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services of Pennsylvania's medical assistance program, more than 220,000 of the 430,000 potentially eligible children have been screened, giving the state one of the best records in the nation. In spite of that fact, many thousands of children have yet to be reached.

In order to receive federal funding for EPSDT, the State Department of Public Welfare must insure outreach programs to find and screen eligible children. In Pennsylvania each eligible family is given a written explanation of the program at least once a year. It briefly explains the nature of the program and encourages the family to contact their board of assistance to make a screening appointment.

Outreach programs must be backed up with a sufficient number of health care providers to carry out actual screening and treatment. Although most counties in the state have adequate personnel for screening, several counties are in great need of physicians and dentists to carry out and supervise screening services. Counties needing personnel are: Allegheny in the western part of the state; Dauphin in the central part; Philadelphia, Bucks, Chester, Delaware, and Montgomery in the southwestern region; and Lehigh and North-

ampton in the northeastern region.

The American Academy of Pediatrics has long been in support of EPSDT and has urged participation in the programs by their members.

EPSDT was endorsed by the American Medical Association Committee on Health Care of the Poor during the 1973 National Symposium of Professional Health Care Provider Participation in EPSDT. A major recommendation of the symposium was, "State and local medical societies and specialty organizations should actively seek involvement with EPSDT agencies in their locales in an effort to provide their expertise and services as needed. Also, these professional organizations should inform and encourage their membership to participate in this program."

EPSDT's purpose is to treat as well as to detect problems before they become chronic or disabling. Of the 220,000 children screened in Pennsylvania so far, 49 percent have had treatable abnormalities, usually, dental, visual, or hearing problems.

According to Ann Gropp, director of DPW's Bureau of Public Information, screening services are provided at more than 500 sites across the Commonwealth. The sites encompass the whole range of medical providers including private offices, group practices, clinics, and hospitals. All offer the same quality controlled screening test package. The average screening takes 30 to 45 minutes and includes hearing, vision, and dental check ups, the taking of a detailed health history from the parent, height and weight checks, some simple lab tests, and a check on the completeness of the child's immunization status. Other tests may be

performed as the physician determines. All screening is carried out under the supervision of a physician although paraprofessional personnel are used to save the client's time.

Under federal regulations, screening for the 0-18 month age group should take place at 2, 4, 6, 9, 12, and 18 months, as recommended by the American Academy of Pediatrics, and for the 19 months to 20 year age group screening should take place every two years.

According to the regulations published in the October 9, 1976, *Pennsylvania Bulletin*, a provider must be "a licensed physician, a group of licensed physicians, or an appropriate agency" which must be able to furnish all facets of general pediatric services . . . and must be furnishing these services to other children, and must be certified as an EPSDT screening provider by the Bureau of Medical Care Systems."

For each child who is screened, providers must send to the County Board of Assistance a special form which states whether or not the child has been referred for treatment or needs to be referred.

In order to insure uniform screening and minimize waste, the Department of Public Welfare reimburses providers at a package rate.

Physicians and dentists in Philadelphia, Bucks, Chester, Montgomery, and Delaware Counties who want to participate in the Early Periodic Screening, Diagnosis, and Treatment program should contact the Philadelphia Health Management Corporation at (215) 629-0575. Those in the remainder of the state may call the Health Screening Research Foundation in Pittsburgh at (412) 344-4111, or in Harrisburg at (717) 232-9711.

HAP has new officers

Clive R. Waxman, Jr., president of the Williamsport Hospital, has been chosen to serve as chairman of the Hospital Association of Pennsylvania (HAP) in 1977.

Recently selected as chairman elect, to serve as chairman in 1978, was Carl L. Mosher, president of the Presbyterian-University of Pennsylvania Medical Center in Philadelphia.

Category I TV course available in Pennsylvania

Participation in a unique symposium next spring can earn up to 34 hours of Category I continuing medical education credits without travel and meetings. "Infant Nutrition: A Foundation for Lasting Health?" is the three-hour, closed circuit television symposium which will be presented March 23 in Pittsburgh, Philadelphia, and 17 other cities in the United States and Canada.

Sponsored by the University of Iowa College of Medicine, the symposium is part of an ongoing medical project which will extend over a two year period. Other components include a pre-program self-assessment examination developed by the sponsoring institutions and the National Board of Medical Examiners, who will also score the exams; a post-program assessment; a series of monographs and films; a visiting faculty program; and a newsletter entitled "Dialogues in Infant Nutrition" which will provide answers to questions raised before and during the telecast.

Chairman of the symposium will be L. J. Filer, Jr., M.D., Ph.D., executive editor and professor of pediatrics at the University of Iowa College of Medicine and former chairman of the American Academy of Pediatrics Committee on Nutrition.

Other faculty members are a distinguished panel of scientists and clinicians prominent in the fields of pediatrics and nutrition.

Working in cooperation with the Iowa College of Medicine are: the National Heart, Lung, and Blood Institute; the National Kidney Foundation; the Committee on Atherosclerosis and Hypertension in Childhood; the American Heart Association Council on Cardiovascular Disease in the Young; and the Canadian Paediatric Society.

If used and completed as de-

signed, the entire program meets criteria for 34 Category I credits toward the Physician's Recognition Award of the American Medical Association. Estimated time spent on the program components are as follows: television symposium, 3 hours; "Dialogues in Infant Nutrition" newsletter, 8 issues at one hour per issue; pre-program and post-program exams, 7 hours each; and the visiting faculty program, 3 programs

of 3 hours each.

The closed circuit television presentation will be shown in Pennsylvania at the following two locations: Benjamin Franklin Hotel, Ninth and Chestnut Sts., Philadelphia 19105; and Pittsburgh Hilton, Gateway Center, Pittsburgh 15230.

For further information contact Pat Coleine, Health Projects International, Inc., 200 Madison Ave., New York, NY 10016.



AMONG THE ACTIVITIES during the Auxiliary's annual meeting was the Gavel Club Annual Dinner. Shown seated, left to right, are: Mrs. Norman H. Gardner, AMA Auxiliary president; Mrs. John A. Schneider; Mrs. Leroy A. Gehris; Mrs. John H. Eves; Mrs. Richard T. Smith; Mrs. Raymond C. Grandon; Mrs. Frank J. Corbett; and Mrs. Axel K. Olsen. Standing, left to right, are: Mrs. H. Morrison Hancock; Mrs. Drury Hinton; Mrs. Walter Orthner; Mrs. Ralph S. Blasiole; Mrs. Edward Dennis; Mrs. Frederick R. Gilmore; Mrs. Malcolm W. Miller; Mrs. Robert F. Beckley; and Mrs. C. Henry Bloom.



SHOWN IN ATTENDANCE at the Auxiliary's annual meeting are, left to right: Mrs. Norman H. Gardner, AMA Auxiliary president; Mrs. Richard T. Smith, State Auxiliary president; Mrs. Edmund Housel, Philadelphia Auxiliary president; and Mrs. George W. Patterson, speaker of the House of Delegates.

AMA protests unnecessary regulations

MATTHEW MARSHALL, JR., M.D.
Pittsburgh

Matthew Marshall, Jr., M.D., first president of the Pennsylvania Medical Care Foundation, comments on and explains the reasoning behind two resolutions introduced into the American Medi-

cal Association House of Delegates by the Pennsylvania Delegation. The resolutions, both dealing with governmental regulatory measures, were approved by the AMA House in June 1976.

Useless fire/safety code requirements waste money

For some time the public has recognized the necessity for fire and safety standards in health care institutions and both HEW and JCAH have set standards. However, conflicting regulations have caused confusion and, as a member of the Western Pennsylvania Comprehensive Health Planning Agency, I was appalled at the necessity of diverting needed health care capital construction funds to apparently useless projects required to meet such standards.

Some light was cast on the validity of several construction requirements when the American Health Care Association conducted a study entitled, "Fire Test in a Nursing Home" under contract with HEW, Bureau of Quality Assurance. This is the bureau responsible for administering the PSRO program.

None of the institutions caring for your patients can afford to spend money unnecessarily, so it is

important that all physicians join in an effort to avoid this waste. The AMA approved the following resolution introduced by the Pennsylvania Delegation.

RESOLVED, That the Department of Health, Education and Welfare be urged to declare a moratorium on enforcement of those Life/Safety Code requirements which do not have a demonstrated relationship to patient safety, until an evaluative mechanism can be established to determine what standards are actually necessary to assure patient fire safety; and be it further

RESOLVED, That the Department of Health, Education and Welfare use the results of the study, "Fire Test in a Nursing Home Patient Room," as a basis for granting relief to institutions which have been cited for violation of code regulations invalidated by the study, until such time as alternative regulations are adopted.

Delineating medical staff privileges—how much is needed?

Prior to the June 1976 annual meeting of the AMA, the JCAH required medical staffs to delineate privileges, and while agreeing that laundry lists were not necessary (but acceptable) had not defined an acceptable alternative to the laundry list. Moreover, it begged the question of their necessity rather than to define their purpose. Felch,¹ observing that a system defining privileges has evolved, states, "medical staffs will need to consider several elements. Dimension, specificity, elasticity and process" (all requiring considerable time and paper work on the part of the individual physician and medical staff). He states, "It doesn't matter how privileges are developed, so long as the process is fair and rational . . . the public demands that we identify with considerable precision the staff member's professional activity in the hospital." Or do they?

I believe this is an erroneous assumption. The public demands that services they receive from physicians are performed competently and they really have little interest as to whether the particular services they receive match their attending physician's list, except to the extent that the process may provide their attending attorneys with additional grounds for malpractice suits.

There are usually two sides to every issue and delineation of privileges should be recognized as having potential for interfering with quality care if used restrictively for economic purposes or in this malpractice climate. It can make physicians hesitant to perform procedures which might not be on the list, primarily through fallibility of foresight. Furthermore, delineation of privileges should be recognized as another bureaucratic function of medical staff activity that must justify the time and effort it requires of both the medical staff and the individual physician. The public does have a right to know the general field of competence of the members of the medical staff and that continued staff privileges are dependent upon a continuing process of evaluating their training and experience. It is important that delineation of privileges be placed in its proper perspective as an aid in the accomplishment of these goals rather than an end unto itself.

For this reason the following resolves were endorsed by the Pennsylvania Delegation and adopted by the AMA House of Delegates:

RESOLVED, That the purpose of delineation of privileges is to provide broad guidance to those persons with a legitimate interest in information re-

Northumberland society hears malpractice update



AVAILABILITY of medical liability insurance was the topic of a recent meeting of the Northumberland County Medical Society. David S. Masland, M.D., immediate past president of the State Society, served as the main speaker. Photographs of the meeting were taken by George R. Wentzel, M.D., secretary of the county society.

SHOWN at the right at the Northumberland society meeting are, left to right: James E. Paxton of the PMS staff; Clarence Everett, director of pharmacy of Rea and Derick, host for the meeting; Dr. Masland, George A. Rowland, M.D., chairman of the Society's Board of Trustees; and D. Ernest Witt, M.D., speaker of the House of Delegates.



Delineating . . . continued from preceding page

garding the general field of competence of members of the medical staff; and be it further

RESOLVED, That granting privileges in a recognized medical specialty or specialties should imply competence in those procedures generally recognized as being within the scope of that specialty or specialties without the need for the medical staff to paraphrase in whole or in part the limitations of that specialty; and be it further

RESOLVED, That a medical staff, when it believes such action appropriate to best serve the interest of the public and with reason, may extend or restrict a staff member's privileges, with or without the approval or request of the staff member, subject to due process; and be it further

RESOLVED, That when any member of the medical staff has demonstrated his competence by his past record of training and experience, and the medical staff believes he is capable of performing in the same competent manner in the future, great care should be exercised by the medical staff in setting a policy for delineation of privileges, that the policy does not make any member hesitant to perform procedures for which he is qualified through fear of malpractice suit for failure to conform to that policy;

and be it further

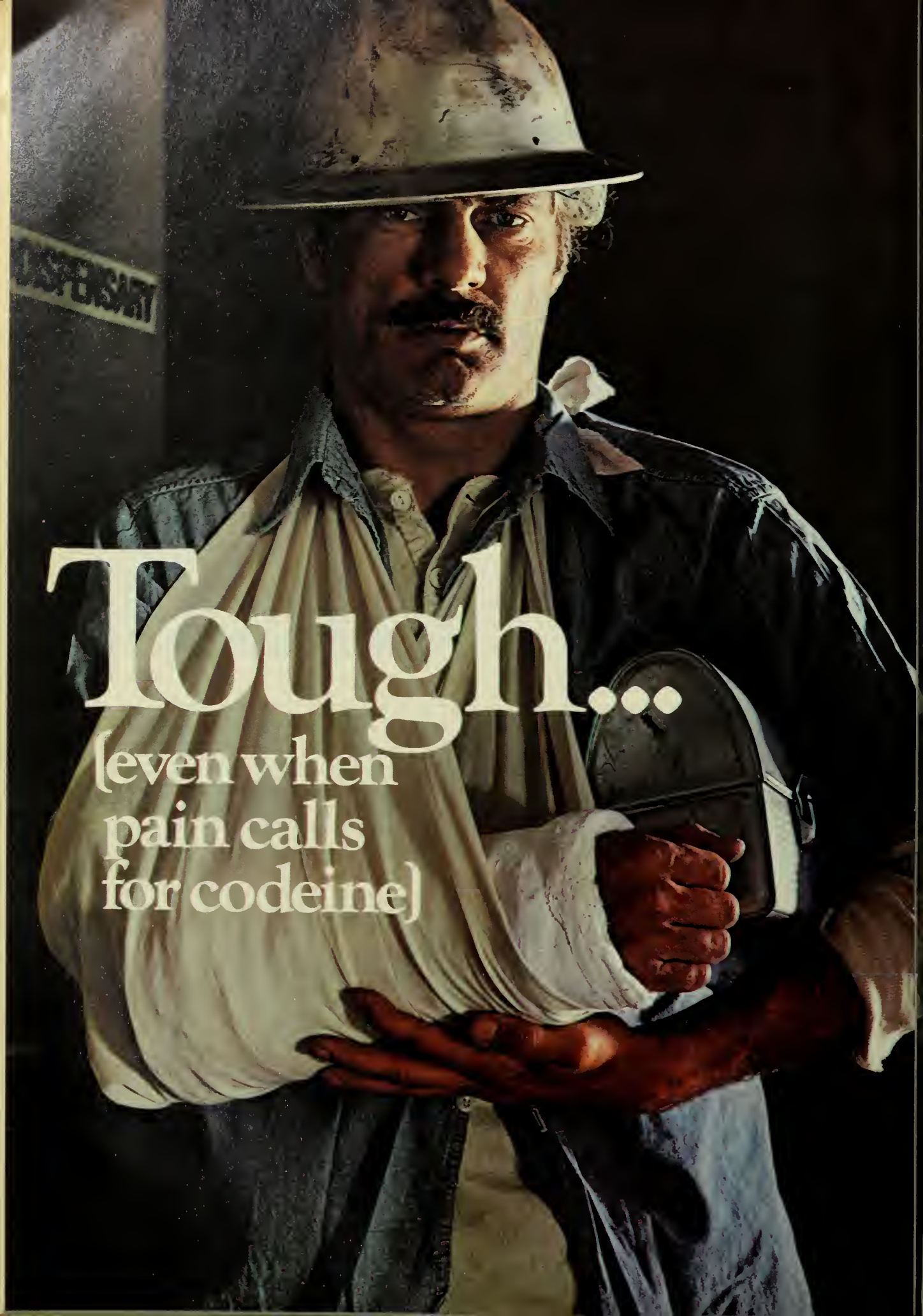
RESOLVED, That the AMA representative to the JCAH be guided by this policy when formulating guidelines for medical staff bylaws; and be it further

RESOLVED, That the AMA representative to the JCAH be guided by this policy in forming JCAH policy on delineation of privileges for members of the medical staffs.

Porterfield,² recognizing the debate at the AMA, has stated that the board of the JCAH, while not apparently accepting these resolves, "has suggested as a reasonable intermediate position that privileges be defined somewhat along the parameters, so far as they have been clearly enunciated, of the various specialty boards in clinical medicine. Even these definitions will need to be applied flexibly depending upon the available manpower resources in a given location, the needs of the population served, and the availability of alternate resources." Is JCAH policy getting clearer?

REFERENCES

1. Felch, W.C. Views from the chairman. The Hospital Medical Staff, August 1976, pp. 14-17.
2. Porterfield, J.D. Accreditation clinic. The Hospital Medical Staff, September 1976, pp. 18-20.

A man with a mustache, wearing a white hard hat and a dark work shirt, is shown from the chest up. He is holding a large, white, crumpled bag or sack over his shoulder. The background is dark and industrial, with a sign that partially reads "DISPER" visible on the left. The lighting is dramatic, highlighting the man's face and the texture of the bag.

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Usage in ambulatory patients. Caution patients that acetaminophen and codeine may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery.

Interaction with other CNS depressants. Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) may exhibit additive CNS depression; when used together reduce dose of one or both.

Usage in Pregnancy. Safe use is not established. Should not be used in pregnant patients unless potential benefits outweigh possible hazards.

Precautions: *Head injury and increased intracranial pressure.* Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal condition. Acetaminophen and codeine or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

Special risk patients. Administer with caution to elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, or prostatic hypertrophy or urethral stricture.

Adverse Reactions: Most frequent are lightheadedness, dizziness, nausea, and vomiting; more prominent in ambulatory than in nonambulatory patients; some may be alleviated if patient lies down; other: euphoria, dysphoria, constipation and pruritus.

Drug Interactions: CNS depressant effect may be additive with that of other CNS depressants. See Warnings.

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*Mielke, C.H., et al.: JAMA
235:613 (Feb. 9) 1976.

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A doctor's philosophy for investing

LEIF C. BECK, LL.B.

VASILIOS J. KALOGREDIS, J.D.

Bala Cynwyd

We are often presented with questions regarding physician-clients' investments, either through their retirement plans or by themselves personally. Our basic approach is to avoid direct answers for three reasons: (1) we are no more "expert" in that field than are the questioners; (2) even the investment counsellors and analysts deserve only mixed claims to success at best; and (3) any reply will sooner or later be wrong. Our cynicism notwithstanding, some sort of response should be provided and we hope in this article to present an idea of our underlying philosophy for physicians.

Physicians' advantages

As a first factor in the investment decision, we believe the physicians' general economic superiority should be recognized. Physicians are as a class the highest income earners in the United States. Our experiences tend to confirm that fact, for rarely do we encounter a doctor or group in less than extremely comfortable financial circumstances. (This statement must, of course, be recognized in comparison to the whole of society, for certainly we see doctors who are "hurting" financially on incomes of \$50,000 and more.)

We also believe that the physician's high income opportunity is far more likely to extend until his retirement than for any other group in society. Medical care will always be a vital commodity commanding high pay. Even the supposed threats of national health insurance, fee controls, and oversupply of providers are hardly likely to change a doctor's comparative high income standing. His risk of becoming unemployed, or even of becoming unable to earn a disproportionately large salary in relation to others, is very small.

As a result of these economic advantages, the typical physician would seem best advised to be an extremely conservative investor. He can probably reach his various personal and family financial goals far more certainly than can other members of his

community. His concerns should, we submit, be to accumulate and compound his available funds steadily even if undramatically. He doesn't need to speculate for especially high, but risky, returns since the loss would slow down his progress while the big gain would be less necessary to meet his goal.

Physicians' attitudes

While observing doctors' routinely high incomes (in relation to the community, not just to their neighbors), we are also struck by most doctors' attitudes towards money. Fortunately for our society, physicians seem to us to be generally more concerned over their professional work product than for the money it earns them. This "pureness" of philosophy is admittedly far easier to maintain when one is well-paid, but at any rate it is an aspect of medical practice that makes us proud to be somehow involved. (The test of a group's loyalty to professional ideals is, we fear, most severely presented if its members are being squeezed economically.)

Doctors' comparative disinterest in "financial games" should dissuade them from playing those games for high stakes. For other types of people, a big gain may be an emotional victory of its own; we find, on the other hand, that doctors are, as a class, less driven for such "victories."

Furthermore, doctors typically have the least time to devote to good financial analysis. By training, a doctor refers to and relies upon experts' advice—even if the "expert" is his friendly, commission-oriented salesman. As an investment becomes more susceptible to risk we believe a greater degree of independent evaluation is required, but the doctor is by professional preoccupation and trustfulness least able to give that level of attention. The doctor is often financially naive.

These circumstances similarly lead to our belief that doctors should as a class be the most conservative investors. They lack the inclination, as well as the need, to give inordinate attention to the complexities of the money game; and they have enough patient problems to avoid the emotional highs and lows of that game.

The authors are the principal consultants of Management Consulting for Professionals, Inc., Bala Cynwyd.

Our prescription—conservatism

We believe that steady investing in securities having minimal "down-side risk" is the preferred course for most physicians. We are less concerned with the income-earning potential than with the prevention of loss. And we would shy away from the seller of a new opportunity in favor of our simple instinct for continued slow progress. Such an attitude is not exciting, and we sometimes fear being accused of "hardening of the mental arteries" because of it (as Mr. Beck once was so accused in an article written by an insurance salesman.)

The attitude requires particular challenge whether it will protect a physician and his family from the ravages of continued inflation. We believe it will meet this test so long as the investing is followed systematically through the years. The accumulation of the basic dollars (increasing in amounts as all values inflate) should meet the increasing goal even if the rate of return is somewhat less than the inflation rate. What is even more certain, the accumulation will be more successful in coping with cost-of-living rises than will a loss on a higher-risk investment designed to "beat the inflation rate."

As to personal investments, we are not satisfied that the stock market provides the answer. Our clients have ridden that market up, down, up, and down the values to the extent that their success is more a matter of when it is measured than of underlying real growth. Similarly, the most successful mutual funds and/or investment counsellors of one year are the biggest losers the next year, so that we believe choosing a fund or counsellor is as risky as choosing a stock investment itself. The market simply rises and falls for reasons which no one can consistently predict, and we have found no consistent basis for anyone (broker, Wall Street analyst or physician) to choose better within those cycles than anyone else.

We thus would rely heavily on high quality, interestbearing investments diversified enough to minimize losses. Commercial paper, U. S. Treasury notes, bank certificates of deposit, and even plain old savings accounts would become good choices. High-grade tax-exempt municipal bonds, again diversified, would also be desirable with the added feature of tax savings. If these investments should return only 6 percent to 7 percent, we believe they would serve their purpose of accumulating for the future.

Real estate may be the only speculation we feel can serve the doctor well. Land is indeed a limited commodity, and it is one which the doctor can evaluate somewhat more reliably. Except to the extent of heavy borrowing, furthermore, the down-side risk

would normally be far less than for investments in other companies' business activities through the stock market.

Our emphasis on land precludes investing through real estate partnerships where the seller's interest is more in selling the share than in making the project succeed. We are routinely skeptical of any syndicate marketed through brokers or others in sales activity. The advantage of land is the doctor's ability to relate to and understand the project, even perhaps to partially *control* it, something he cannot do as owner of a share in a limited partnership.

"Tax shelters"

We do not consider it unfortunate for a doctor to pay substantial income taxes. Even a 50 percent tax rate means he has the other 50 percent available for his use and/or investment. As we have suggested to an insistent client: "If you want to reduce your taxes, we will be happy to increase the fees we charge you, which will be deductible!"

The desirability of a tax shelter investment is not in the amount of the write-off. It is instead in the amount of money one will likely have when the investment has run its course. This question seems to receive far less attention from tax-shelter salesmen than it should.

Federal tax policy has provided certain "sheltering" advantages (reduced by the recently-adopted Tax Reform Act) in order to attract investors. The reason investors required the additional incentives was simply that the underlying investments carried more risk than would otherwise be acceptable. These economics tend to hold true even today, and so we question why an oil operator might sell off shares if its likelihood of return were so good that it could borrow the funds and keep the profits for itself.

We are thus not easily impressed by tax-shelter proposals. They put at high risk the possibilities of losing money (which hurts even if tax deductible), which in turn runs counter to what we believe best serves the typical physician—systematic, uninterrupted compounding.

Conclusion

Next month we will apply our underlying attitudes to physicians' retirement plans, whether Keogh plans, professional corporation plans or the new IRAs. In the meantime, we hope this oversimplified discussion will be useful to the readers in establishing a basic philosophy. It is exemplified by one final, but basic, gut feeling: "You work too hard to lose your earned money in investments." □

The Volunteer Faculty Association

Jefferson Medical College/Thomas Jefferson University

invites physicians to attend a presentation at
6 p.m., Tuesday December 14, 1976

Solis-Cohen Auditorium
Jefferson Alumni Hall
Tenth and Locust Sts., Philadelphia

Meeting will be followed by cocktails and dinner
at the Faculty Club at 7:30 p.m.

Participants

Robert L. Brent, M.D., professor of radiology, pediatrics, and anatomy
and chairman of the Department of Pediatrics at Jefferson

Paul J. Fink, M.D., professor of psychiatry and chairman of the
Department of Psychiatry and Human Behavior at Jefferson

Lindsay L. Pratt, M.D., professor of otolaryngology and chairman of the
Department of Otolaryngology at Jefferson

Topic: Co-existence

volunteer - part time - full time faculty

1. Involvement in federal and state programs
2. Privileges—admitting, promotion, tenure, etc.
3. Consultations and referrals
4. Committee structure
5. Unassigned patients

Audience participation to follow
Students, interns, and residents welcome

For cocktail and dinner reservations contact:
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* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioğlu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25

(methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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PRECAUTIONS: With Bronkotabs therapy sympathomimetic side effects are minimal. However, frequent or prolonged use may cause nervousness, restlessness, or sleeplessness. Bronkotabs should be used with caution in the presence of hypertension, heart disease, or hyperthyroidism. Drowsiness may occur. Ephedrine may cause urinary retention, especially in the presence of partial obstruction, as in prostatism.

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NEOSPORIN® Ointment (polymyxin B-bacitracin-neomycin) is a famous fighter, too.

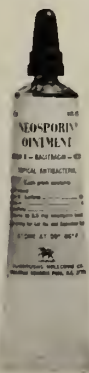
Provides overlapping, broad-spectrum antibacterial action to help combat infection caused by common susceptible pathogens (including staph and strep).

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to

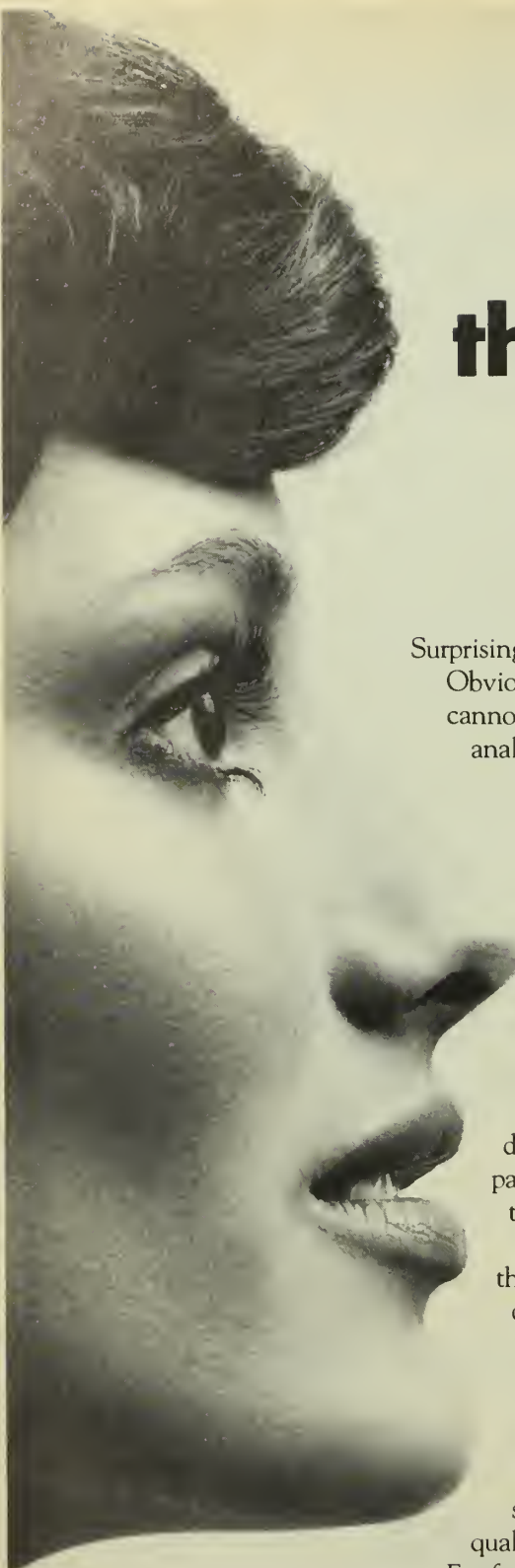


neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Otcotoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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The one the patient takes is never tested.

Surprising, perhaps, but it makes sense when you think about it. Obviously, the actual dose of any prescription drug the patient takes cannot be tested because it would have to be broken down for analysis — after which it could never be used by a patient.

This means that you depend on the manufacturer for assurance that the dose the patient takes is identical to the ones which have been tested.

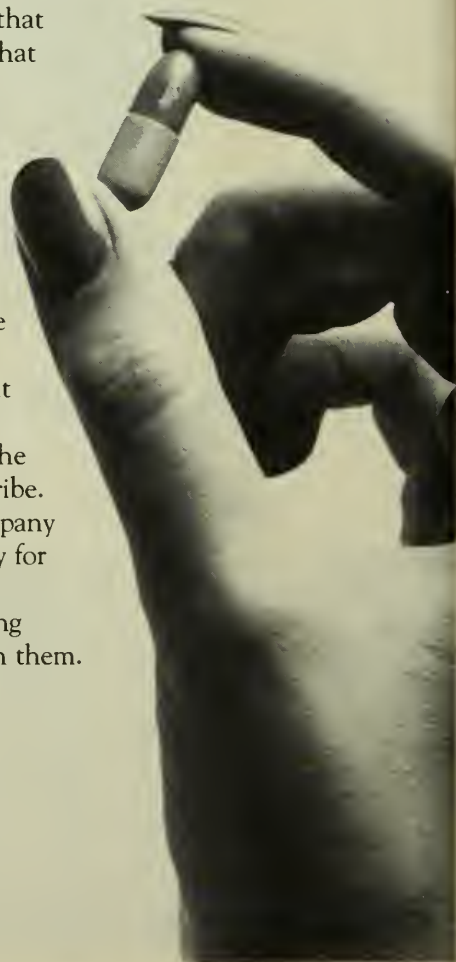
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Can public understand when 'pros' don't?

Several weeks ago, the following paragraph appeared in "The Pros," the official newsletter for employees of the Bureau of Professional and Occupational Affairs of the Pennsylvania Department of State, of which the State Bureau of Medical Education and Licensure is a part.

MAL-PRACTICE—One of the things that all P&OA staff folk should be aware of is the fact that if a doctor or a hospital performs poorly on you or a loved one, causing harm, the doctor or the hospital is liable for such harm. Mal-practice insurance will pay for such harm. Don't be afraid to sue. An arbitration board has been set up to hear your case and the insurance we are requiring for the doctor or hospital to carry will cover you.

The malpractice crisis is not purely a doctor problem. Reasonable persons can foresee that society will ultimately bear the burden of malpractice, through increased medical costs to cover premiums either by the patient directly or by third party payers. For the past several years, physicians have been seeking responsible solutions to increasing rates, contingency fees, nuisance suits and carrier withdrawals through the established channels—insurance department hearings, legislation, and the courts. In spite of these attempts, malpractice is still an unresolved issue for the practicing doctor. Rising rates, policy cancellations, and carrier withdrawals have made the situation extremely difficult. To date, nine state medical societies, including our own, have opted for doctor-owned malpractice insurance companies and several others are considering them. The rates are generally higher than those offered by commercial carriers if they are available. Pennsylvania has legislated a Joint Underwriting Association to provide liability insurance for those physicians who are unable to obtain coverage through other means. This too has proved expensive and impractical as a long term solution to the

malpractice crisis.

The medical profession's attempts to find practical solutions to a complex social problem are impeded by exhortations (as above) which interpret Act 111 as a law passed to compensate any patient or relative for any bad outcome. The irresponsibility represented by this position typifies the provincial attitude that has precipitated the current crisis. Figures recently released by the American Medical Association indicate that office visits in 1975 were 96¢ higher than they would have been if malpractice premiums had stayed at 1973 rates. The average office visit in 1975 cost \$15.23, of which \$1.24 went toward the purchase of malpractice insurance, while the 1973 rates were \$12.42 and 30¢ respectively.

Until there is a better public understanding of the malpractice problem and its causes, malpractice rates will continue to soar and will be manifested in increased cost of medical care to patients. How much more of this burden can be borne before the collapse of patient care as we know it either through loss of competent specialists who are unable to practice because they are unable to obtain or pay malpractice insurance or before health services become so expensive that other methods of physician compensation will be adopted by the third party payers.

To stop this abuse of malpractice insurance, attitudes will have to change. Consumerism must be controlled and government employees will have to understand that laws are passed to protect everyone and are not intended as a new way to get rich quick.

At this time of year, we should all pause to reflect not only to give thanks now, but also to find ways to extend the spirit of Christmas to the other 51 weeks of the year.

David A. Smith, M.D.
Medical Editor

I was sick and ye visited me

The following is a verbatim excerpt from an office newsletter, "The Pros," which is the official newsletter for employees of the Bureau of Professional and Occupational Affairs of the Department of State, Commonwealth of Pennsylvania.

MAL-PRACTICE—one of the things that all

P&OA staff folk should be aware of is the fact that if a doctor or hospital performs poorly on you or a loved one, causing harm, the doctor or the hospital is liable for such harm. Don't be afraid to sue. An arbitration board has been set up to hear your case and the insurance we are requiring for the

doctor or hospital to carry will cover you.

Shame on you, Ms. Delores Tucker, Secretary of the Commonwealth, and on you, The Honorable Governor—Saviours of the People—for allowing conniving, deceitful, and unethical conduct by the editors of the newsletters and their collaborators—"Servants of the Taxpayers."

Is it any wonder that the cost of health care (defensive medicine) is escalating in frightening pro-

Dr. Lovette, a contributing editor to PENNSYLVANIA MEDICINE, was elected vice president of the State Society in September. He has served as speaker and vice speaker of the House of Delegates.

Guest editorial

Debate, 'Who's who in plastic surgery' continues

Most surgeons—general surgeons, orthopedic surgeons, ophthalmologists, otolaryngologists, etc.—constantly use well described and well understood plastic surgical principles. Dr. Marlowe's figures concerning those who do plastic surgical procedures are a bit low since virtually all general surgeons, for example, use skin grafts, and most of them handle them very well. Most surgeons, and indeed most pediatricians, as well as emergency room physicians and general practitioners, care for facial lacerations, lacerated fingers, and a host of other similar problems. They have learned to use fine suture material and to respect the general principles of plastic surgery in caring for the wounds.

Well trained physicians have often rotated through our training programs in plastic surgery and we are glad to have them, but they are not plastic surgeons, and they do not call themselves plastic surgeons.

In the same way, we in plastic surgery overlap with many other surgical fields. We care for fractures in the facial area as well as crush and avulsion injuries of the hand, but we do not have board certification in orthopedic surgery and do not call ourselves orthopedic surgeons. We remove many skin lesions, benign and malignant, we operate on eyelids, ears, and noses, but lacking board certification in these

Dr. Randall is professor of plastic surgery, I. S. Ravdin Institute, Hospital of the University of Pennsylvania. This editorial presents another opinion than that expressed by Frank I. Marlowe, M.D., in the September issue.

portions? No wonder malpractice claims, 99 percent of which are false, frivolous, and fraudulent, are rising.

Is it any wonder the cost of malpractice insurance is driving physicians, young, middle aged, and old, from this state?

Is it any wonder that the public antipathy against government has dipped to a point lower than a whale's belly in the deepest part of the ocean?

Who gets skizzled? The poor patient. As the sickness spreads and the patient sinks, would it not be reasonable to say:

"Come Ye Blessed of My Father
I was Sick and Ye DIDN'T visit Me."

John B. Lovette, M.D.
Johnstown

areas we do not call ourselves dermatologists, ophthalmologists, or otolaryngologists. All of us are responsible for our patients' general medical condition, and we have patients who show and need care for anxiety and depression, but we do not call ourselves internists or psychiatrists.

There is a growing number of physicians, usually otolaryngologists, who call themselves "facial plastic surgeons." They limit themselves almost exclusively to the field of aesthetic surgery and refer to "regional" plastic surgery. These "limited plastic surgeons" usually are not board trained or board certified in plastic surgery. They may have had good training in rhinoplastic surgery and perhaps even in face lifting and blepharoplasties, but in no way is it conceivable that their training has or should have included reconstructive surgery of the breast unless the "T" "ENT" has taken on a new meaning. Yet, often this is considered within their domain.

Many young surgeons in otolaryngology, orthopedics, and some of the other surgical specialties who have wanted plastic surgery training have elected to take the two years of residency training in plastic surgery required by the American Board of Plastic Surgery for certification. In fact, the American Board of Plastic Surgery will now accept board certification in a number of surgical fields as equivalent to the required three years of general surgical training, and we have had two such residents in our own training program. Plastic surgeons have always stressed the need for a strong background in general surgery, and last year over 80 percent of those residents in plastic surgery training programs in this country had sufficient training in general surgery to

be eligible for certification in general surgery as well.

However, in the same way that we in plastic surgery do not call ourselves otolaryngologists, orthopedists, or ophthalmologists, even though our fields overlap, it stands to reason that these "limited

plastic surgeons" lacking board certification in plastic surgery really should not be known as plastic surgeons but rather by the specialty wherein they hold certification.

Peter Randall, M.D.
Philadelphia



correspondence

Flood victim says 'thanks'

To the editor:

I am very happy to enclose a check for \$1000—the final payment, I believe, in my Hurricane Agnes loan from PMS and the AMA. I am sure that ours are the only organizations that would have come to the aid of members so soon following a disaster and at no interest. Not only did they lose income on the monies disbursed but it actually cost them to disburse the monies. I am happy to have signed up way back in '33 or '34.

We are much back to normal but it will never reach normal. I am certain that structural changes to the residence and office will continue to manifest themselves for years to come.

Again—happy to be "square"—happy to be a member—and happy to still have a roof over my head, with many thanks and best personal regards, I am very truly yours,

Herman A. Fischer, Jr., M.D.
Wilkes-Barre

Researcher seeks information

To the editor:

I am currently engaged in research on the Munchausen (Hospital Addiction) Syndrome and its variants. I would like to correspond with any other physicians who have had personal contact with such patients. To this end I would appreciate it if you would print this letter in your Correspondence section. All responses should be addressed to:

S.E. Hyler
5620 Netherland Avenue
Riverdale, New York 10471

October cover questioned

To the editor:

The quotation on the front cover of the October issue of PENNSYLVANIA MEDICINE — "Go To Hell Washington and Take Harrisburg With You" — is

bad taste, and is bad public relations as a headline for the magazine representing medicine in Pennsylvania.

The article may be true, false, or controversial, but the general public merely sees this headline. We should feel ashamed to have post office employees see this, or for it to be seen by the general public. You may think this old fashioned and ultraconservative, but the pediatrician who sees young children and adolescents daily cannot help but admire those who train their children to have a civil tongue. I certainly believe you could have publicized this article and gotten the same readership with a less offensive and radical-appearing front cover.

I am interested in the reactions of your readership to my criticism.

Milton Sarshik, M.D.
Philadelphia



"... And just where the hell do you plan to start?"



The Hahnemann Medical College and Hospital of Philadelphia

The Department of Diagnostic Radiology

The Department of Medicine

Announces

The Fifth in a Series of Conferences on the Diagnosis of Organic Brain Disease

Conference Subject:

Computerized Axial Tomography in Clinical Medicine: *Incidence of Visualized Organic Brain Lesions Correlated with Presenting Clinical Symptoms—Results in Approximately 6,000 CAT Brain Scans Performed Over a Two-Year Period*

Lecturer:

Wilbur W. Oaks, M.D., Professor and Chairman, Department of Medicine, The Hahnemann Medical College and Hospital

Accreditation:

Approved for 1½ hours of AMA Category I credit per session.

Computerized Axial Tomography (CAT) Brain Scan at Hahnemann

From July, 1974 through June, 1976, approximately 6,000 CAT brain scans have been performed at Hahnemann. A prospective study was established at the outset for the correlation of presenting clinical symptoms and CAT findings. Beginning in July of 1976, clinical data compiled during the previous two years were keypunched for computer processing. This work has been completed and the results obtained will be presented at this conference.

The presentation of these data will closely follow the organizational format of the recently published work:

Patricia D. Laffey, Wilbur W. Oaks, R. Kumar Swami, J. George Teplick, and Marvin E. Haskin: *Computerized Tomography in Clinical Medicine*. Medical Directions, Philadelphia, 1976.

This format provides for the correlation and incidence of CAT findings with the clinical signs and symptoms associated with: ● Headache ● Seizures (generalized and focal) ● Disturbance of intellectual function (personality change, dementia, psychomotor retardation) ● Ataxia and disturbance of gait ● Motor and sensory dysfunction ● Visual disturbance ● Trauma.

Of paramount interest, approximately 75% of the patients in this large group have been ambulatory outpatients.

Date: Tuesday, December 14, 1976

Time: 6-7:30 P.M.

Place: Geary Auditorium, Hahnemann Medical College, 15th and Vine Streets, Philadelphia, Pa. 19102

For further information on future conferences contact: Department of Diagnostic Radiology, Hahnemann Medical College and Hospital, Philadelphia, Pa. 19102. Telephone: (215) 448-8510.

Go to hell, Washington, and take Harrisburg with you

Vital facility lives one day at a time but on its own

ABRAHAM J. TWERSKI, M.D.

Pittsburgh

'... Every single morning I give thanks to the Lord that our federal grant request was turned down. ... The recovery of a person addicted to alcohol appears to be a miracle. At the Gateway Rehabilitation Center, the miracle has occurred hundreds of times in a setting which is in itself a miracle - a multi-million dollar treatment facility, constructed and operated without one cent of federal funds.'

To paraphrase Job, Washington giveth, and Washington taketh back, but Washington keepeth its hands in the pie forever.

Federal grants are something else. First, they sometimes provide nothing. We became aware that had we not had a federal grant, we could have really done just as well, because the amount received from federal funds had to be deducted from hospital charges. That is, if we had received say \$500,000 a year from the federal government, we had to lower the hospital rates, and if we had not had the federal grant, the same services could have been provided via the usual sources of hospital payment.

What we gained from having the federal government was the

pleasure of having "site visits" and audits from government representatives. Site visits are very important in governmentally-funded programs. They are an excellent method to reduce unemployment, because they pro-

This is the fourth in a series by Dr. Twerski, entitled "Go to hell, Washington, and take Harrisburg with you!" which is reprinted from the Pittsburgh Press. Dr. Twerski is medical director of the Gateway Rehabilitation Center and clinical director of the department of psychiatry in St. Francis General Hospital, Pittsburgh.

vide jobs for people who can run around inspecting.

The investigators come in for one or two days to review the operation. They are either geniuses who without any formal training in psychiatry can review a hospital and/or clinic in eight hours and point out to the specialists who operate it 365 days a year exactly what is wrong (if they are such geniuses, why are they working in the lowest echelon of government?). Or they are simply fakers, who look around and don't know what they are looking at, then go back and write a report. Or, most probably, they are typically governmental "paper people" who look over your books, statistics, data sheets, etc., and whom you can bamboozle by showing them a bunch of figures that they can

neither prove nor disprove. I cannot grant them the distinction of the first possibility nor do I wish to insult them with the second, and I therefore opt for the third.

Now you must understand that a "site visit" investigator isn't all that secure about his job. He is quite like an IRS man, who must discover some discrepancy in your income tax return to show that he is on his toes and deserves to remain on his job. Hence, the investigator *must* find something to write home about, and advise you in writing that on his recent visit he finds that you are not properly complying with subsection C of Section 2318, and subsection B & D of Section 2322. Before he leaves he drops a gentle hint that everything really looks pretty much okay and not to get too excited if you receive a letter from the higher-ups that you are in non-compliance with something or other. By the time the next site visit occurs, there will be other investigators anyway, who will not pay any attention to last year's report, and will be looking for their own discoveries, because they get no brownie points if all they can do is follow up on someone else's revelations.

We did run into a snag of a different sort. We had initially estimated that we would need about 100 beds to serve our population, and we therefore requested funds to staff that many beds with appropriate nursing personnel. At the end of the first year, we advised our federal contact that we had overestimated the number beds by about 50 percent. He told us for God's sake not to return any money from the grant, because this is something that had never happened, and the computers in Washington are simply not programmed to deal with money returned. We would therefore be causing a calamity the magnitude of Pearl Harbor if we were to return funds. Fur-

thermore, the agency has every intention of asking Congress for an even larger appropriation for next year, and they just cannot tolerate having any unspent money. I distinctly remember him saying, "Buy paper clips with the money if you have to, but just don't send it back." Of course, this was not put in writing, and since I was not living in Washington, it did not occur to me to tape our conversation, so that, although we used the money to pay nursing personnel who were serving other patients, (instead of buying paper clips) we were defenseless when four years later a group of investigators wanted to know where the hell the excess money went to, since the patient census figures in the mental health center did not justify all those nursing personnel.

Needless to say, the various levels of bureaucracy have to have something to do, and once they have an address of a grantee, they are in the clover. First, it does their egos good to write memos and directives on federal government stationery, and I think they feel like they have delivered a State of the Union message or written something equivalent to the Preamble to the Constitution. Second, they have a feeling of omnipotence, making threats to discontinue grants if you do not do as they wish. Third, they feel like a benefactor uncle when they can call you that they have just discovered a way that you can qualify for an expansion grant. From the numbers of reports they mail out, collect, and process, I am certain that for every dollar that is spent in actual patient care, there are at least five dollars spent on backup paper work. Incidentally, all these tons of stuff are mailed out without postage, so that the postal system is driven even deeper into the mud.

As a result of an open-door admission policy, St. Francis had a

very large number of patients admitted because of acute alcohol intoxication. In fact, St. Francis has the distinction of being the first general hospital in the United States to admit patients under a diagnosis of alcoholism. Many hospitals had an extremely restrictive policy regarding admission of acute alcoholics, and in those instances where the patient was an influential person and could not be refused, he was apt to be admitted under a subterfuge diagnosis of "gastritis" or the like.

Observing some 900 people a year for a week or so of "drying out," I concluded that we were grossly lacking in providing adequate treatment for the alcoholic. True, we had an active outpatient clinic, and we had dedicated members of Alcoholics Anonymous who would visit our patients and hold regular meetings in the hospital; but this still was not enough.

It was apparent that the person who came in for "drying out" was generally someone addicted to alcohol rather than just out "on a toot," and had often had brief periods of sobriety before. Yet, he had been unable to sustain them. A few patients had been fortunate enough to join AA immediately after discharge, but the majority of people, after drying out, went back to the same environment without having learned any new way to adapt to any stress situation other than by resorting to drink. In some situations, the wife, who had already witnessed several (or several dozen) of these short-lived periods of sobriety, and who really had no reason to believe this time would be any different, would greet the husband with a verbalized or non-verbalized, "I wonder how long this one is going to last." Unknowingly, the wife's anticipation of a relapse often helped bring it about.

It was therefore evident that something else had to happen between the time the patient was released from drying out and his return to his previous environment. This "something else" was a period of intensive treatment, where the person could learn new ways of coping with the frustration from whatever sources, rather than by escaping into the anesthesia or euphoria of alcohol. We had had some experience with referring patients to such a treatment facility some 300 miles away, but the remoteness was an undermining factor. There was no effective way of making the transition from inpatient to outpatient treatment an uninterrupted one, and many patients relapsed in this stage.

There was a great deal of grassroots support for developing a treatment facility of this kind, and an expression of financial aid by local industries and foundations. We began looking for an appropriate building to house such a program, since what we had in mind was a one-month live-in treatment program. We therefore had to have a building large enough to house at least 50 beds, with adequate kitchen facilities, office space, grounds, etc. This was difficult to find, and those that came under consideration were ruled out by zoning restrictions and neighborhood objections. No one wanted any "drunks" nearby.

The only option left was to get a plot of land outside of the city, and build the facility we needed. We began investigating sources of federal funds in Washington, but there was none to be had for construction. Billions were being spent for the craziest things, but no way to get a facility built that could do some good.

It was then discovered that although no grants were available, there was a provision that a federal bureau could underwrite a

loan to construct, among other things, "a nursing home for alcoholics." This would of course mean an enormous mortgage, interest, etc., but it seemed to be our only option. Incidentally, we had no idea how in the world such a facility would support itself because even those insurance policies that did cover alcoholism treatment limited this coverage to treatment in a general hospital, and there were no provisions for payment in a rehabilitation facility. I discussed this problem with Sister and we both agreed that we did not have a leg to stand on and that the whole venture was a pipedream; but since it was something that we were certain could offer effective treatment to people, we had to go ahead with it anyway.

After gathering all the necessary data demonstrating beyond any doubt the crying need for such a treatment facility in our area, I presented the data to Washington. The feds indicated they were ready and willing to guarantee the loan and all I needed was a statement from Harrisburg, the capital of Pennsylvania, that they would issue a license for the facility as a "nursing home" for alcoholics.

Harrisburg informed me that they could provide a license for a nursing home for alcoholics, provided we meet the construction and staffing standards for nursing homes. They explained that this meant special beds, bed-pan rinses in every room, special bathtubs for the physically handicapped, special toilets, handrails all over the place, etc., which would add hundreds of thousands to the construction cost. Then the staffing would have to include a large number of registered and practical nurses per day, evening, and night shifts, etc. I advised them that the patient population we would be serving were all physically healthy peo-

ple, all of whom would have already undergone a period of "drying out" prior to admission, that they were there for a psychological rehabilitation program, and that there was no need for all the special gadgetry and the number of nurses required.

Harrisburg responded that there was no way they could issue a nursing home license unless these criteria were met and that since what we were planning was not really a "nursing home" in the usual sense of the word, we should apply for license as a "mental health facility," which could be obtained with ease and did not have all these requirements. I conveyed this message to Washington, but the feds said that they were very sorry. Nowhere in their regulations did it state that they could underwrite a "mental health facility," only a "nursing home" and that there was no way around this.

I then called Harrisburg and told them what the federal dingbats had said. They were very sympathetic, but did not see how they could help. I told them exactly how they could help, namely, by issuing a license for a nursing home and waiving all the specifications that were inappropriate for our patient population. I told them that we were ready to go ahead with our program and this foolish bickering over terms was terribly obstructive. I carried the issue to high levels of state government but got nowhere. They could not waive requirements because they had to go by what the piece of paper said, and a "nursing home" according to their piece of paper had to be x, y, and z. Again, they would be happy to give me another classification of license, but not a nursing home, unless I provided the regulation number of bedpans and an adequate number of nurses to carry them.

Back to Washington, "Hey,

can't you people realize that it doesn't make any difference what the thing is called that you are underwriting? The facility will operate in the same fashion whether it is called a 'nursing home' or a 'mental health facility.'"

Washington: "Sorry, Sir. We have to go by our regulations. When you send us the piece of paper that says 'nursing home' license, we will underwrite you."

Me: "Don't you realize that this stupid semantic impasse is preventing a desperately needed treatment program from becoming operative? What difference does it make what it is called? Anyway, you're not giving away money, just underwriting a loan."

Washington: "We understand your problem, Doctor, but what we cannot seem to get you to understand is that we have to go by our regulations. We cannot underwrite a 'mental health facility' loan, only a nursing home loan. You get us that piece of paper, and we're in business."

It was at this point that I hung up the phone and uttered the words that I have chosen as the title for this series of articles—"Go to hell, Washington, and take Harrisburg with you."

For four months I tried in vain to get the two regulation-obsessed organisms to come to an understanding, and with each futile attempt more hairs of my beard turned prematurely gray.

The whole thing was reminiscent of a game called "Captain, May I?" which we played as little kids, wherein one child would stand at one end of the room, and a group of kids would line up at the other. The solo child was the captain, and issued orders to advance forward in giant steps, baby steps, or whatever. You had to ask, "Captain, may I," after the command was given, and if the Captain approved, you could advance. If you reflexly obeyed the

command and advanced without asking "Captain, may I" first, you were penalized and had to go all the way back to the starting point.

I am sure I stopped playing the game by my seventh birthday, because no self-respecting seven year old would be involved in something so infantile. Yet, here we were apparently mature adults, hung up over a magic password, quite similar to the "Captain may I" game. The fact that at stake was a program that could save lives made it a far cry from child's play.

Then the Lord in His infinite mercy brought an end to this dilemma, when Harrisburg created a new entity known as an "Intermediate Nursing Home." Since there were neither construction nor staffing standards for this new creature, there was little difficulty in issuing the license, and the Washington paper people had their magic word.

Although I had already been wisened by previous experience with federal grants, I nevertheless applied for the grant to staff the new treatment center.

In addition to the previously mentioned drawbacks, I must mention another: federal grants self-destruct after a period of time. You are then left in the lurch with either dropping or sharply curtailing the program you have started, often discontinuing a helpful service and throwing many people out of their jobs. Or you must come up with some other type of support, usually by bringing enough pressure on local government that they have to bail you out, which makes them angry at you and leaves everyone with a bad after taste. Nevertheless, I was desperate to get the program going, and took the risk of involvement with the feds.

I should have listened to the pundits who advised me that the experience in Washington is: the better the program, the less are its chances of being funded. The

reason? Bad programs, sensing their inadequacies, hire the best professional grant writers who know exactly how to write the gobbledegook that Washington thrives on. Those who are confident in the merit of their program, feel the value of their endeavor will be obvious to everyone; hence they do not wish to waste the money to hire a professional grant writer. Consequently, they do not present the program in the Washingtonian parlance, and get nowhere. We got nowhere.

We opened our treatment facility over three years ago. We have lived from payroll to payroll, never knowing how we will keep our doors open. Yet, every single morning I give thanks to the Lord that our federal grant request was turned down. As a result of this refusal, we have learned to economize, and *it can be done*. We do not have endless visits by auditors, site investigators, and other federal busybodies. We can devote our time to care of our patients without having to fill out thousands of forms and reports which no one will ever read or use. Finally, the experience of living "one day at a time," trying to do whatever we can with whatever we have today, and not permitting our function today to be hindered by the worry of how we are going to survive next week, has enabled us to be of maximum help to our alcoholic patients, who also have to learn to live one day at a time, and cope with great tensions and frustrations.

The recovery of a person addicted to alcohol appears to be a miracle. At the Gateway Rehabilitation Center, the miracle has occurred hundreds of times in a setting which is in itself a miracle—a multi-million dollar treatment facility, constructed and operated without one cent of federal funds. □

(Continued next month.)

FUTURE MEETING DATES PENNSYLVANIA MEDICAL SOCIETY

Board of Trustees

1977—January 12	Headquarters Building
March 16	Headquarters Building
May 18	Headquarters Building
August 24	Headquarters Building
October 24	Host Farm Resort Motel, Lancaster
Upon Adjournment of House of Delegates	Reorganization Meeting
November 30	Headquarters Building
1978—January 18	Headquarters Building
March 15	Headquarters Building
May 17	Headquarters Building
August 23	Headquarters Building
October 30	Host Farm Resort Motel, Lancaster
Upon Adjournment of House of Delegates	Reorganization Meeting

Annual Business Session

1977—October 25-27	Host Farm Resort Motel, Lancaster
1978—October 31-November 2	Host Farm Resort Motel, Lancaster
1979—November 1-3	Penn Harris Motor Inn, Camp Hill
1980—October 30-November 1	Penn Harris Motor Inn, Camp Hill

Medical Arts '77

1977—November 18-19	Hershey Motor Lodge and Convention Center
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Officers' Conference

1977—April 13-14	Hershey Motor Lodge and Convention Center
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AMERICAN MEDICAL ASSOCIATION

Annual Convention

1977—June 18-23	San Francisco, California
1978—June 17-22	St. Louis, Missouri
1979—June 23-29	New York City
1980—June 21-26	Las Vegas, Nevada

Clinical Convention

1977—December 4-7	Chicago, Illinois
1978—December 2-6	Chicago, Illinois
1979—December 1-5	Chicago, Illinois
1980—December 6-10	Chicago, Illinois



MDs in the news

Mildred C. J. Pfeiffer, M.D., M.P.H., received the Distinguished Service Medallion of the American Heart Association, Pennsylvania Affiliate, during the organization's recent annual meeting. Additionally she recently received the Pennsylvania Public Health Association's special award for outstanding contributions to public health. She is a medical and public health consultant for the Pennsylvania Department of Health's Office of Public Health Programs.

Alfred G. Knudson, M.D., was recently named director of Philadelphia's Institute for Cancer Research, to assume duties in January. Presently Dr. Knudson is dean and professor of medical genetics at the University of Texas Graduate School of Biomedical Sciences, Houston, and professor of pediatrics at the medical school. He is professor of biology and pediatrics at the M. D. Anderson Hospital and Tumor Institute.



DR. KNUDSON



DR. GRAY

Frank D. Gray, M.D., was recently appointed chairman of the department of medicine at Jefferson Medical College, Thomas Jefferson University. He is a professor of medicine at Jefferson and director of the division of medicine at the Lankenau Hospital. Dr. Gray is a governor for Pennsylvania of the American College of Chest Physicians and a member of the Council on Cardiovascular Physiology of the American Heart Association.

Leroy A. Gehris, M.D., Reading, was recently named a fellow of the American Academy of Family Physicians. Dr. Gehris is trustee and counselor for the Second Council District of the State Society.

The following physicians were recently named fellows of the American College of Surgeons: **John W. Docktor, M.D.**, and **Ronald L. Paul, M.D.**, of York; **William E. Burak, M.D.**, and **William Smedley, M.D.**, of Kingston; **Chan Kun Chung, M.D.**, and **George P. Moses, M.D.**, of Wilkes-Barre; **Jung Pil Lii, M.D.**, and **David A. Cope, M.D.**, of Reading; **Chikkanarsappa Mahalingappa, M.D.**, of Charleroi; **E. Lawrence Harasym, Jr.**, Bloomsburg; **Louis J. Sabol, M.D.**, Danville; **Larry H. Hunter, M.D.**, **Larry H. Lytle, M.D.**, and **Nicholas W. DiCuccio, M.D.**, of Lock Haven; **James R. Bastian, M.D.**, Williamsport; and **Mark F. Paris, M.D.**, Roaring Spring.

Frank S. Bryan, M.D., was recently named a fellow of the American College of Surgeons during the organization's Annual Clinical Congress in Chicago. Dr. Bryan is an orthopedic surgeon in Carlisle.



DR. BRYAN



DR. BRAY

Susan H. Bray, M.D., Wyndmoor, was recently elected to the Board of Corporators of the Medical College of Pennsylvania. She is codirector of the college's hypertension center and a clinical assistant professor at the college.

Larry W. Jones, M.D., Roaring Spring, was named a fellow in the American Academy of Ophthalmology during the organization's recent annual convention.

Harry Shubin, M.D., was elected recently as secretary of the American Academy of Medical Administrators. Dr. Shubin is medical director and administrator of Center City Hospital, Philadelphia.

Jack D. Myers, M.D., president of the American College of Physicians, was recently elected to a five year term in the Institute of Medicine of the National Academy of Sciences. Dr. Myers is university professor at the University of Pittsburgh School of Medicine and has served as professor and chairman of the department of medicine since 1955.

The National Heart, Lung, and Blood Institute of the National Institutes of Health recently awarded **Lewis Kuller, M.D.**, a three year research grant of \$400,000 for the investigation of high blood pressure in the young. Dr. Kuller is chairman of the department of epidemiology in the Graduate School of Public Health at the University of Pittsburgh. Coinvestigators are: **Katherine Detre, M.D., Ph.D.**, associate research professor of epidemiology; **Joseph Schachter, M.D.**, associate professor of child psychiatry; and **Kenneth D. Rogers, M.D.**, chairman of the department of community medicine in Pitt's School of Medicine.

T.O. Savidge, M.D., Lewisburg, president of the Union County Medical Society, was elected recently as president of the American Heart Association, Northcentral Pennsylvania Chapter, Inc. He has served on the executive committee and the board of directors of the northcentral chapter.

Anton M. Miller, M.D., St. Clair, was recently awarded a membership in the American Medical Association 50 Year Club of American Medicine in recognition of 50 years in the practice of medicine. Previously Dr. Miller had received citations from the Disabled American Veterans, the Four Chaplains, and the U.S. Congress for his many years of service.

Harry S. Ziemer, M.D., was recently honored for more than 50 years of medical practice in the borough of Adamstown. He received a commemorative plaque during a special community service.

Prayun Chayapruks, M.D., was recently certified by the American Board of Internal Medicine. A diplomate in pediatrics, Dr. Chayapruks is on the medical staff of the Greene County Memorial Hospital in Waynesburg.

Clara J. Ersoz, M.D., was appointed recently as medical director of St. Clair Memorial Hospital in Mt. Lebanon. She is assistant professor of anesthesiology and coronary care medicine at the University of Pittsburgh School of Medicine and chief of critical care medicine at St. Clair.

Paul J. Fink, M.D., was appointed recently as professor and chairman of the department of psychiatry and human behavior at Jefferson Medical College, Thomas Jefferson University. He was previously professor and chairman of psychiatry and behavioral sciences at the Eastern Virginia Medical School in Norfolk, Virginia.

Charles K. Zug, III, M.D., Bethlehem, was appointed chief of the department of surgery in St. Luke's Hospital in Fountain Hill. Dr. Zug is president of the Northampton County Medical Society and chairman of the Pennsylvania Medical Political Action Committee (PaMPAC).

Alton I. Sutnick, M.D., and **Paul F. Engstrom, M.D.**, have edited a new book, *Oncologic Medicine: Clinical Topics and Practical Management*, a collection of 24 wide ranging chapters by a distinguished group of cancer specialists. Dr. Sutnick is executive vice president and dean and professor of medicine for the Medical College of Pennsylvania. Dr. Engstrom is director of medicine for the American Oncologic Hospital, Fox Chase Cancer Center, and assistant professor of medicine for the University of Pennsylvania School of Medicine.

Donald W. Spigner, M.D., was appointed recently as public health officer of Harrisburg. He is an associate professor of clinical medicine at the Milton S. Hershey Medical Center and medical director of Harrisburg's up-town health center.

William DeMuth, M.D., was recently named editor of the Pennsylvania Emergency Health Services Council newsletter. Dr. DeMuth is a professor of surgery at the Milton S. Hershey Medical Center, chairman of the State Society's Commission on Emergency Medical Services, and on the board of directors of the Pennsylvania Emergency Health Service Council.

Isamu Sando, M.D., was appointed recently as associate professor of otolaryngology at the University Health Center of Pittsburgh and associate professor of pathology at the University of Pittsburgh School of Medicine. He is former associate professor of surgery/otolaryngology and director of research at the University of Colorado Medical Center.

Robert Zelis, M.D., was recently named president elect of the American Federation for Clinical Research. He is a professor of medicine and chief of cardiology in the Pennsylvania State University College of Medicine at Hershey.

Donald M. Friedman, M.D., recently became director of the new division of rheumatology in the Crozer-Chester Medical Center, Chester. In addition, Dr. Friedman has been named assistant professor of rheumatology at Hahnemann Medical College and Hospital.

The American Cancer Society, Philadelphia Division, recently held elections of new officers. They are as follows: **Luther W. Brady, M.D.**, president; **Milton H. Donaldson, M.D.**, and **N. Henry Moss, M.D.**, vice presidents; **Dominic A. DeLaurentis, M.D.**, **Peter N. Magee, M.D.**, **Janet A. Parker, M.D.**, and **Frederick Urbach, M.D.**, members of the board of directors.

Cyril H. Wecht, M.D., was recently selected Outstanding Alumnus of 1976 by the University of Pittsburgh Chapter of the Omicron Delta Kappa fraternity. Dr. Wecht is Allegheny County coroner, director of the Pittsburgh Institute of Legal Medicine, and holds faculty positions on the University of Pittsburgh's schools of medicine and dentistry and graduate school of public health.

Indru T. Khubchandani, M.D., Allentown, was recently appointed associate director general of the International Society of University Colon and Rectal Surgeons. He is president elect of the Lehigh County Medical Society.

Rex. H. Newton, M.D., was chosen recently as Pittsburgh Physician of the Year for 1975-76 by the Pittsburgh Committee for Employment of the Handicapped. Dr. Newton is a psychiatrist in the Harmorville Rehabilitation Center.

George R. Roth, M.D., was certified recently by the American Board of Neurological Surgery. He is an assistant neurosurgeon at Harrisburg Hospital.

David K. Wagner, M.D., was named recently as a professor of surgery at the Medical College of Pennsylvania. Dr. Wagner heads the sections of emergency medicine and pediatric surgery at the college. He is president elect of the American Board of Emergency Medicine.



DR. WAGNER



DR. SHENKIN

Henry A. Shenkin, M.D., was recently appointed professor and head of the section of neurosurgery at the Medical College of Pennsylvania. Dr. Shenkin is director of the department of neurosurgery and head of the neurosurgery residency program at the Episcopal Hospital.

Herbert I. Soller, M.D., and **Arthur J. Muller, D.O.**, both of Harrisburg, were recently certified by the American Board of Internal Medicine.

Nicholas J. Ruggiero, M.D., was appointed recently as director of cardiology at the Wilkes-Barre General Hospital. Dr. Ruggiero is director of the hospital's cardiac catheterization laboratory.

PMS-AMA Membership Categories, Dues at a Glance

The PMS Benefits designated below as "all" include participation in or eligibility for:

Appointment to commissions, committees and councils; election to office; the right to vote
Automobile leasing program
Discount magazine subscription program
Group insurance programs
PMS Professional Liability Insurance Program
Disability Income Plans
Exceptional Risk Disability Income Plan
Executive Major Medical Coverage
Excess Major Medical Coverage
Business Overhead Expense Plan
Accidental Death and Dismemberment Plan
Individual Life Insurance Program
Group Life Insurance for Professional Corporations
Hospital Indemnity Program
Workmen's Compensation Dividend Plan
Medical Benevolence Fund
Medical Education Resource Center
Educational Fund
Pennsylvania Medical Care Foundation
PSRO Information
Legal opinions on medico-legal questions
Counsel on questions of medical ethics
Peer review on request in disputes involving third parties
Input on legislative matters through an effective lobby
Medical staff bylaws information
Pennsylvania Medical Cooperative
PENNSYLVANIA MEDICINE
Physician Placement Service
PaMPAC
Speech writing service
Public relations counsel
Free health education pamphlets

Membership Classifications PMS and AMA Dues Purposes

ACTIVE MEMBER-Any physician who is fully licensed to practice medicine and surgery in the Commonwealth of Pennsylvania and is a member of a component society. Also, any physician who is employed full-time by the federal government in a civilian or military capacity and does not hold an unrestricted license to practice medicine and surgery in the Commonwealth of Pennsylvania.

Dues: PMS - \$150.00
AMA - \$250.00 (AMA dues may be excused (1) by reason of financial hardship or illness or, (2) over age 70.

Benefits: PMS - All
AMA - All except publications for AMA dues exempt are available only by subscription.

MILITARY - (ACTIVE MEMBER) - Any active member serving temporarily in the armed forces or other federal government service (before March 1).

Dues: PMS - Dues-exempt.
AMA - \$35.00

Benefits: PMS - All
AMA - All

DISABILITY - (ACTIVE MEMBER) - Any Active Member who is prevented from the practice of medicine by reason of illness or disability.

Dues: PMS and AMA - Dues-exempt
Benefits: PMS - All
AMA - Same as AMA dues exempt (1) above.

INTERN and RESIDENT - Any Member serving a hospital internship, residency, or other recognized full-time postgraduate training.

Dues: PMS - \$15.00 (10% of regular assessment)
AMA - \$35.00

Benefits: PMS - All
AMA - All

SENIOR ACTIVE MEMBER - Any member at least 65 years of age on January 1 with at least 30 years continuous membership (membership in other states or AMA may be included).

Dues: PMS - \$75.00 (50% of regular assessment)
AMA - \$250.00 (AMA dues may be excused (1) by reason of financial hardship or illness, or (2) over age 70).

Benefits: PMS - All
AMA - Same as Active Member except publications for AMA dues exempt are available only by subscription.

AFFILIATE MEMBER - Any member of a component society not engaged in active practice within the jurisdiction of the component society who belongs to one of the following classes:

- members of national medical societies or foreign countries.
- American physicians whether or not licensed to practice medicine and surgery in Pennsylvania engaged in missionary or philanthropic labors
- full-time teachers of medicine or of the arts and sciences allied to medicine who are not holders of an unrestricted license to practice medicine and surgery in the Commonwealth of Pennsylvania.
- physicians not fully licensed to practice medicine in Pennsylvania who are engaged in Pennsylvania in research or administrative medicine
- physicians, whether or not fully licensed to practice medicine in Pennsylvania, who are retired from active practice
- physicians in active practice who move out of the Commonwealth of Pennsylvania if they maintain active membership in a county society and the state society in their new state of residence. Members in this category are not eligible for any Society-endorsed insurance programs.

Dues: PMS and AMA - Dues-exempt
Benefits: PMS - cannot vote or hold any office, serve as a delegate, member of a commission, committee, or council, and is not entitled to benefits of Medical Benevolence Fund or Educational Fund
AMA - Same as Associate Member

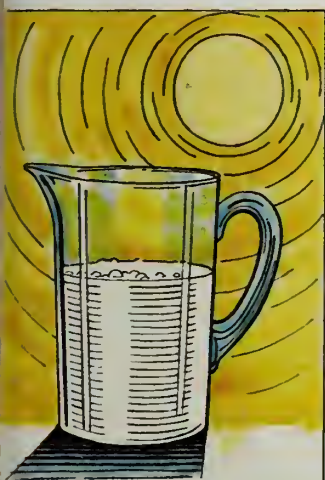
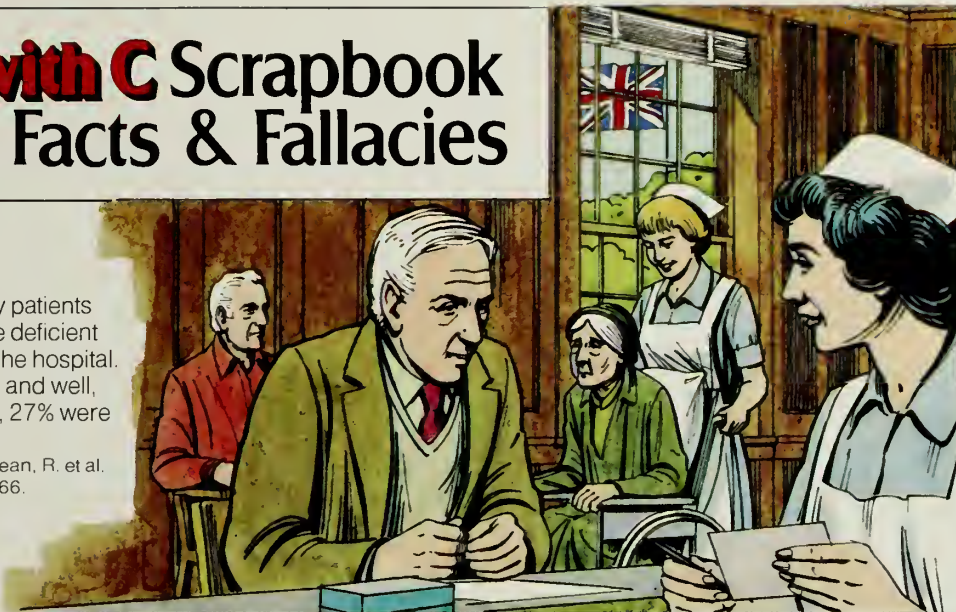
ASSOCIATE MEMBER - Any Active or Senior Active Member who is at least 70 years of age and who has at least 30 years continuous membership (membership in other states or AMA may be included).

Dues: PMS and AMA - Dues-exempt
Benefits: PMS - All—except cannot vote, hold any office, serve as delegate, member of commission, committee, or council.
AMA - May not vote or hold office and will not receive scientific publications except by direct subscription.

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A study conducted among elderly patients in England showed that 41% were deficient in ascorbic acid on admission to the hospital. Even among those living at home and well, or not sufficiently ill for admission, 27% were deficient in ascorbic acid.

Griffiths, L.L., Brocklehurst, J.C., MacLean, R. et al. *Diet in Old Age*, Brit. Med. J., 1:739, 1966.



The loss of riboflavin in milk in a glass container exposed to sunlight for two hours may be as high as 95%.



Quick freezing of vegetables is accompanied by very little ascorbic acid loss. But blanching, washing, and prolonged standing at room temperatures results in considerable reduction in Vitamin C content.

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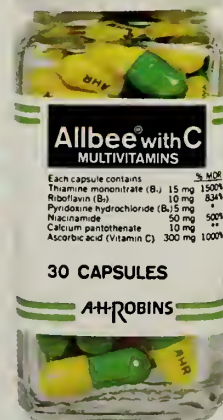


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Phenobarbital	($\frac{1}{4}$ gr) 16.2 mg	($\frac{1}{2}$ gr) 32.4 mg
(warning: may be habit forming)		
Hyoscyamine sulfate	0.1037 mg	0.1037 mg
Atropine sulfate	0.0194 mg	0.0194 mg
Hyoscine hydrobromide	0.0065 mg	0.0065 mg

Indications: Based on a review of this drug by the NAS/NRC and/or other information, FDA has classified the following indications as possibly effective; adjunctive therapy in the treatment of peptic ulcer; the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis. Final classification of the less-than-effective indications requires further investigation.

Brief summary. Contraindicated in patients with glaucoma, renal or hepatic disease, obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy) or a hypersensitivity to any of the ingredients. Blurred vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur at higher dosage levels, rarely at the usual dosage.

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***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

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TESTED LATELY A SIMILAR

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COMFORTABLE HEARING

$\frac{20}{10}$

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IMMEDIATE RELEASE

LIPO-NICIN/100 mg.

Each blue tablet contains:
Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) .. 10 mg.

DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

LIPO-NICIN/250 mg.

Each yellow tablet contains:
Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) .. 10 mg.

DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

GRADUAL RELEASE

LIPO-NICIN/300 mg.

Each time-release capsule contains:
Nicotinic Acid 300 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (H-1) .. 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) .. 10 mg.

In a special base of prolonged therapeutic effect.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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This issue carries no education course listings. The January issue will contain a comprehensive list of continuing education courses being offered in all parts of Pennsylvania. Consult that issue or write for a copy of the supplement to: Council on Education and Science, Pennsylvania Medical Society, 20 Erford Road, Lemoyne, PA 17043.

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Medical cooperative reports successful year

The annual report of the Pennsylvania Medical Cooperative, submitted to the House of Delegates by Co-op President H. Robert Davis, M.D., traces the development and progress of the Co-op during 1975-76. The report follows.

Over five years ago the idea of physicians getting together to form their own business to purchase supplies as a means of lowering office overhead had its beginning in the PMS Council on Public Service (now the Council on Professional Relations and Services). It was a unique idea, an innovative idea, the first of its kind in the country.

From conception to the birth of a growing business was a long and difficult road. First, PMS membership was polled to determine the amount of interest in such a concept. An astounding 70 percent of a random sampling indicated favor for such an idea.

With those hurdles past, a proposal for a marketing survey to confirm the desires of the membership and to explore methods of capitalization for such an enterprise was presented to the House of Delegates and approved in 1972. By 1973, all was in order for the recruitment of members for this organization and funds for such an effort were authorized by the House of Delegates.

The recruitment campaign of members began in the spring of 1974 with a goal of 2,000 members, each contributing \$100 to capitalize the fledgling organization. By September of 1974 the goal had not been reached and the 1974 House of Delegates gave permission to extend the recruitment effort until January and to begin operation. However, it was stipulated that the Society incur no further expense in the Co-op's formation.

During the extended recruitment effort of the Co-op, membership grew to slightly more than 1,800 physicians. It was determined at that time by the PMS Board of Trustees and Councilors that indeed the Co-op should begin even though the Board recognized that the Co-op recruitment program did not meet its capitalization objective.

Even with an early 1975 approval to begin operation, legal problems with incorporation and in the hiring of staff and developing contracts with vendors caused untold delays which made it impossible to open the doors for business before October 1, 1975. This was a year and a half after the initial membership promotion began. Whatever interest and enthusiasm generated by the recruitment program was lost in the delays before the business was operational. In reality, the business had to be started from the bottom by rekindling member interest.

Because of these problems, it was realized early in 1976

that the goal of \$1 million in business for the first year would not be reached. The priority of the Co-op was to survive for several months until physician recognition grew to the point where buying habits were changed in favor of the Co-op.

To say the least, this first year has been difficult for the Co-op. But, it has also been an exciting time. The difficulty of making ends meet during the early months of doing business taxed the Co-op Board and Co-op staff. But it was done! Signs now indicate that this infant organization with a shaky beginning is growing into a viable, healthy, established Cooperative.

The greatest success of the Co-op to date has occurred in its product line. Instead of starting business with only 30 or more products as was originally projected, nearly 250 items were offered. And after a few short months in operation, the product line grew to over 1,300. As this report is prepared the number of products now exceeds 1,500 and management is exploring additional lines of furniture, drugs and pharmaceuticals, and other supplies requested by physicians. It is responding to the calls of membership because physicians run it and own it.

Co-op sales are tied directly to adequate member contact. Ongoing communication with the membership is done via a monthly newsletter entitled "The Mirror." Through the newsletter it is possible to communicate new product lines and ideas of the Co-op and to urge participation by all the members. It has worked dramatically. In addition, a special product page is used to promote selected products and items on sale in order to generate increased sales and participation on the part of members. Other incentives have also been utilized. The results: sales have increased from a low of \$3,000 a week at the beginning of the year to over \$12,000 per week. Because of this growth, failure is no longer a concern of the Co-op. Attention now centers on rapid growth to satisfy the needs of the growing membership in the Cooperative.

When the concept of the Co-op was presented to the House of Delegates, it was presented as an additional benefit to members of PMS and as a means of cutting overhead expenses for those physicians who chose to use it. Has it worked? The Co-op can give an unqualified yes on both accounts. Co-op's prices are lower across the board than all medical supply houses currently serving

physicians in Pennsylvania, and that includes discount mail order firms. What's more, these savings to physicians are significant. Of the entire Co-op membership (1,800), 17 percent have saved enough money by dealing with the Co-op to more than recoup their initial membership fee in the organization. In addition, many of those same physicians have saved enough to pay their state and county medical society dues. Another 33 percent of the Co-op membership are rapidly approaching the time when they will save enough to recoup the Co-op membership fees.

Another plus for the Co-op has been the service to members. Experience has shown that once a physician buys from the Co-op, he comes back again and again. Why? Because the quality of products is there, because a ready staff is there to serve them, and because shipment of supplies is done the same day the order is received and in most cases the shipment is received by the physician within a day or two.

What about the remaining 50 percent of the members not using the Co-op? We have yet to educate them to the value of the Co-op. But we are seeing improvements daily. Our promotion efforts are getting more physicians to become steady Co-op buyers. Word of mouth from satisfied members is also helping. Changing buying habits has been one of the toughest assignments for the Co-op. Certainly the delay in opening the doors for business played a part in members losing confidence in this new concept. Little contact was made with members during the approval stages and incorporation phase of the business. But that is behind the Co-op and we are working to make all members repeat customers.

Co-op growth, both in sales and product line, over the eleven months of its existence has been slow but steady. The record is impressive. But the point remains that growth has not been as rapid as expected to make the organization healthy and independent as it hopes to be and will be in years to come. Too much time is being spent on hand-to-mouth operation with little left for exploring special offers and deals from the many vendors across the country. This will change only when the Co-op has extra

dollars to stock up on certain supplies when the time is right.

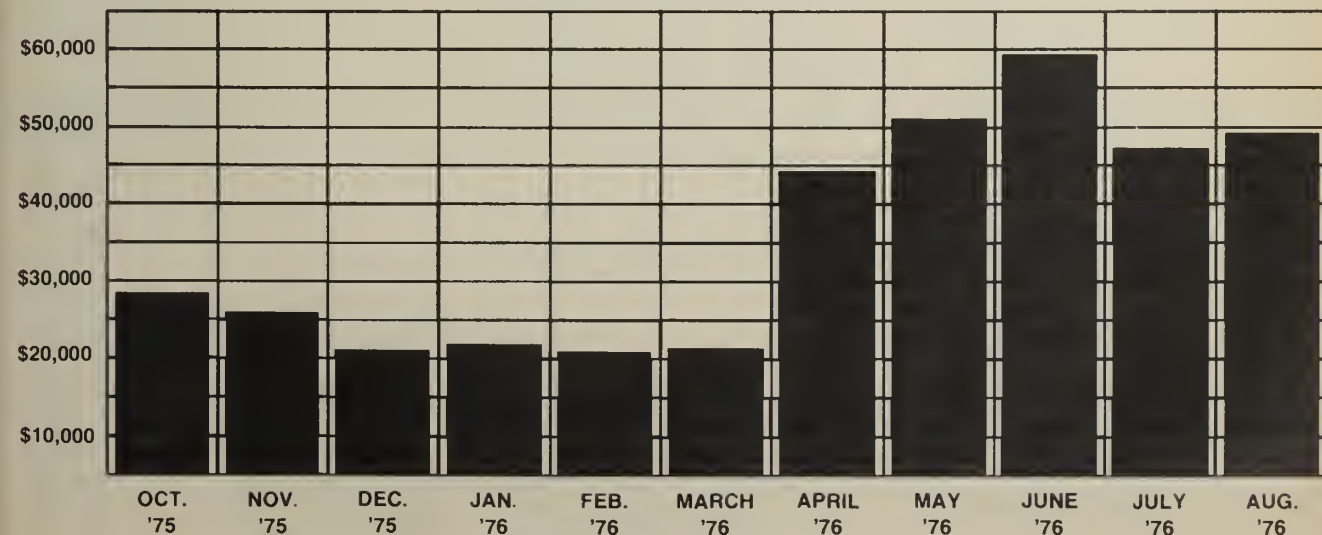
Additional financing would help the Co-op get into areas that would make it more efficient and beneficial to members. These areas include: (1) electronic data processing; (2) inventory of drugs, multiple product brands, office and exam furniture, office supplies, and consumer items; (3) increased advertising; (4) more direct mail with members; (5) a Watts line to receive incoming orders; (6) credit for members rather than always cash with the order; (7) possible salesmen; and (8) more legal advice.

Such expansion requires funds. The Co-op believes that such funding would not be an expense, however. It would be an investment in a unique, viable physician business that will pay dividends once it is over the early hurdles experienced by any new business.

The Pennsylvania Medical Cooperative has a paid membership of 1,800 and because of group association, this represents in excess of 2,800 physicians who are also PMS members. Participation in the Co-op is second only to malpractice insurance of the membership benefits offered by PMS. Can PMS afford to neglect the interest of these members once it has given its blessing for the formation of the benefit? The Co-op thinks not. It hopes not. There is not a large corporation anywhere that would start a new business and then cut it off without any support, staff, legal, financial, moral, etc., from the main organization as was done by PMS when it authorized the formation of the Co-op. There must be additional commitment on the part of PMS before the Co-op can begin paying dividends to all concerned.

The PMS House of Delegates has before it numerous recommendations to overturn a 1974 House decision not to provide any additional support for the Co-op. We strongly urge you to overturn this decision which is hampering the growth of the Co-op. With PMS support, the Co-op can rapidly become a greater asset in membership recruitment. It will become one of the shining examples of why physicians should join and renew membership yearly in PMS.

**PENNSYLVANIA MEDICAL COOPERATIVE
MONTHLY SALES FIGURES**

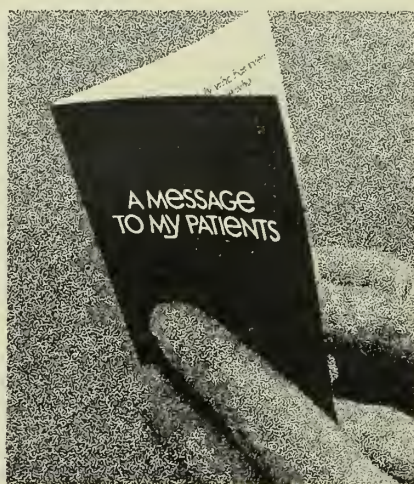


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Treatment of cancer pain

ALFRED TUNG, M.D.

RUBEN TENICELA, M.D.

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Pittsburgh

The Pain Control Clinic of the Presbyterian-University Hospital administers about 5,000 treatments per year to over 1,200 patients. Of these, about 120 have pain secondary to cancer at various locations. The management of cancer pain is a very complex one, and like any other pain syndrome, it requires a multidisciplinary approach.¹

The treatment of cancer pain can be gratifying to a pain clinic physician since the patients have more "obvious" organic causes for pain. However, one must not overtreat such patients even though gross pathology is present and is deemed incurable. Too early use of narcotic analgesics should be discouraged (mainly when non-narcotic analgesics can relieve pain effectively) since it may lead to addiction and tolerance and may make other modes of therapy relatively ineffective. Physicians have the tendency to "snow the patient under because the end is inevitable."² This is true because cancer itself does not usually cause pain in its early development although pain can be a presenting clinical symptom. Severe intractable pain is usually secondary to some complication of the primary diseases.

The usual causes of pain in cancer are: (1) A decrease in interstitial fluid pH in the vicinity of the tumor; (2) compression of nerve roots by the tumor; (3) infiltration of nerve and blood vessels by tumor cells leading to lymphangitis; (4) obstruction of a hollow viscus or blood vessels by the tumor producing infection or ischemia; (5) infiltration of the tumor with swelling of the tissues distending fascia or periosteum; (6) necrosis, infection, and infiltration of adjacent tissues; and (7) pathologic fractures

where bony metastases are present.³

There are two general approaches in treating cancer pain.² One is primary tumor therapy to diminish or destroy the neoplasm, and any pain relief may be incidental. The other is symptomatic pain therapy that does not affect the neoplasm. Both treatments can be administered simultaneously.

Primary tumor therapy may consist of one or more of the following: radiation therapy;⁴⁻⁷ hormonal therapy with or without ablation of endocrine glands;⁸⁻¹¹ chemotherapy with cytotoxic drugs;¹²⁻¹³ and palliative surgery¹⁴ to either reduce the size of the tumor or to treat one or more of the complications, for example, relief of bowel obstruction or drainage of abscess.

As far as secondary symptomatic relief is concerned, attention will have to be directed to both the general care (psychological, nutritional, and social) and specific procedures for pain interruption. Cancer puts a large amount of emotional stress on the patient, his family, and society, especially when the cancer is incurable. In such a case, providing a meaningful life becomes an important issue. Psychological support alleviating the patient's fear and

brightening his outlook will greatly increase his tolerance for pain. Judicious use of antidepressants or sedatives are frequently indicated,¹⁵ and the help of a social worker will take a tremendous load off the patient's worries regarding his finances and the care of his family. Good nutritional care is essential so that he has more energy for an optimal amount of physical activity instead of being bedridden due to weakness. Other symptoms such as nausea, itching, or diarrhea may be more disturbing to the patient than pain. These should be recognized and treated accordingly.

Analgesic drugs

Non-addictive analgesic preparations such as salicylates and acetaminophen can often provide adequate pain relief from mild or moderate pain although they are relatively ineffective against visceral pain. Like any other human pain, the placebo effect¹⁶ also plays an integral part in cancer pain therapy. This applies to any oral medication¹⁷⁻¹⁹ or nerve blocks.

As mentioned before, the use of narcotic analgesics should be saved as a last resort when other acceptable procedures have been tried or when the patient is completely bedridden. Apart from their potent analgesic effect, they also provide euphoria and sedation and are excellent drugs for dying patients.^{17,20}

Specific procedures

The procedures for cancer pain performed at the Pain Control Clinic include nerve blocks with local anesthetics or neurolytic agents, in-

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trathecal alcohol or phenol injections, autonomic plexus blocks (in particular, celiac plexus block), subarachnoid hyperosmolar neurolysis, and cerebrospinal fluid barbotage.

Before any of the patients are subjected to nerve block therapy, a coagulation profile is essential to exclude any clotting factor, deficiencies which may have resulted from previous chemotherapy or radiation therapy, malnutrition, or liver involvement. We have also to be aware of the location of any metastases, especially along the spine, so that we can avoid putting needles through tumor cells.

Local anesthetics with or without depo-steroids are usually used in diagnostic or therapeutic nerve blocks for cancer pain. Although limited in duration of action, they may sometimes provide long periods of pain relief by interrupting the pain cycle which frequently is present in any chronic intractable pain.¹

Diagnostic nerve blocks are usually done before the use of neurolytic agents and any neurosurgical procedures such as neurectomy or rhizotomy. Major neurosurgical procedures requiring general anesthesia such as open cordotomy or tractotomy are usually reserved until simpler procedures have been tried for pain relief.

Percutaneous neurosurgical procedures²¹ usually are safer for debilitated patients, but popular techniques like percutaneous cordotomy²² may lead to complications including loss of sphincter control and apnea.

A few cases of cancer pain have been controlled by the transcutaneous implantation of epidural dorsal column stimulation catheter either as a diagnostic and/or permanent procedure.²³

Neurolytic agents are useful in providing prolonged durations of pain relief of up to months; however, because of their irritant properties, they may produce necrosis, sloughing of superficial tissues, and occasionally post-block peripheral neuritis of the "blocked" nerve.²⁴⁻²⁵ Weaker neurolytic agents (for example, ammonium chloride, 10 percent; ammonium sulfate; potassium chloride; etc.) have been reported to have a

much lower incidence of dysesthesia following the use of peripheral nerve blocks.²⁵

Peripheral nerve block—

Peripheral nerve block is indicated when the pain is localized. Repeated use of local anesthetics is generally tried first especially in patients who are expected to survive for more than three months because of the above-mentioned complications of neurolytic agents. However, we have used 10 percent ammonium chloride for intercostal nerve blocks to relieve chest wall pain and paravertebral posterior division nerve blocks with 3 percent or 6 percent phenol without observing dysesthetic pain.

Any time a neurolytic agent is used for peripheral injection, the patient should be warned of some degree of discomfort at the injection site for twenty-four to forty-eight hours.

The use of various cranial nerve blocks and anterior cervical nerve blocks, using absolute alcohol, for cancer pain in the head and neck area has been successful in terminal patients.

Subarachnoid blocks with neurolytic agents—The use of intrathecal injection of alcohol was first reported by Dogliotti in 1930.²⁶ It has been a useful technique for treating pain in the lower chest and high abdominal areas.

The goal of intrathecal alcohol injection is to cause destruction of the posterior nerve roots selectively, if possible. In the treatment of unilateral cancer pain, the affected side should be up during the injection in order to layer the alcohol to the vicinity of the posterior root since absolute alcohol is a hypobaric solution. The patient should be angled about 45 degrees anteriorly. Such position may be uncomfortable for patients in pain and generally pre-medication with narcotics is required before such a procedure. For bilateral pain, the patient is placed in a jack-knife position so that the alcohol injected will flow in a caudad direction.²⁷ The major complications of this procedure include rectal and bladder incontinence and motor paralysis of the lower extremities. Hypotension may occur if too profound a sympathetic block results.

It appears that alcohol causes de-

myelination and degeneration in the posterior roots and chromatolysis in the posterior root ganglia near the injected level. Maher in 1955 first advocated the use of phenol in a hyperbaric solution for injection intrathecally,²⁸ and he claimed that the spread of such a solution is easier to control compared to alcohol. However, we prefer the use of hypobaric aqueous phenol solution or absolute alcohol for our subarachnoid injections because the "heavy" solutions tend to give patchy blocks. Any late attempt may become difficult because the carrier solution might have formed a protecting coat around the nerve roots.

Nathan, *et al.*, believed that alcohol and phenol derivatives exert both local anesthetic action (which differentiates between types of nerve fibers) and a destructive action (which is nonselective).²⁹

After injection of the neurolytic agent, the patient needs to be immobilized for about 60 minutes to get maximum effect on the nerve roots although it takes only a few minutes for the agents to be fixed.

When absolute alcohol is being used, increments of 0.5 cc are injected through the spinal needle. Further 0.5 cc increments are given at 10 minute intervals until enough optimal sensory loss is obtained. A maximum of 2 cc is used for any treatment. An additional treatment or two may be required but never on the same day.

Celiac plexus block—The celiac plexus block was first described by Kappis in 1914.³⁰ It is particularly useful for pain secondary to carcinoma of the pancreas and other upper abdominal malignancies.³¹⁻³²

The celiac plexus lies around the origin of the celiac artery (from the aorta) in an areolar tissue filled compartment bound behind by the crura of the diaphragm and the body of the first lumbar vertebra, laterally by the kidneys and superrenals, and anteriorly by the pancreas.

Celiac plexus block interrupts the sympathetic and parasympathetic nervous conduction from the viscera. In performing such a procedure, the patient is placed in the prone position and the needle is inserted just below the twelfth rib at its midpoint usually 4-6 cm from the midline. It is angled

initially at about 45 degrees from the skin surface towards the first lumbar vertebra. The lateral aspect of the vertebral body is identified. The needle is then withdrawn and is reintroduced at an increased angulation so that the tip will slip off the side of the vertebral body.

At this point, the patient may feel some epigastric discomfort which signifies a well-placed needle. Radiological confirmation (x-ray at two planes) is usually done before any alcohol injection.

Aspiration during insertion of the needle is important because the needle could be inadvertently inserted into the aorta or the inferior vena cava, the pleural cavity, pancreas, or even the subarachnoid space. Profound hypotension could result from such a block in dehydrated patients, and intervenous injection should be started prior to the procedure. Such a procedure should be considered early in the development of this type of cancer pain before the patient becomes too dehydrated in which case postural hypotension would be a problem.

For diagnostic blocks, usually 20-40 cc of 0.5 percent Lidocaine is injected. For neurolytic blocks, 40-50 cc of 50 percent alcohol in water is used following a test dose of 5 cc of 1 percent Xylocaine. Other complications may increase weakness or numbness in the lower extremity, lower chest pain, urinary difficulties, and impotency.

Subarachnoid saline perfusion—
The use of hypothermic saline in the treatment of intractable pain was first described by Hitchcock in 1967.³³ It was later found by King, *et al.*, that it is not the temperature which is the critical factor but the osmolality of the cold saline solution.³⁴ In Hitchcock's series of seven patients with pain from advanced facial carcinoma, pain relief was achieved, lasting from 3 to 105 days; and there were only transient side effects.³⁵ However, the procedure has the marked drawback of intense pain to the patients on installation of the cold saline into the subarachnoid space; and general anesthesia is usually required.

Cerebrospinal fluid barbotage—
Cerebrospinal fluid barbotage

(that is, withdrawal and reinjection) was first used for treatment of pain by Lloyd in 1972.³⁶ He was successful in relieving pain of up to two months duration in 10 out of 14 patients with cancer. Since 1973, we have used this procedure in twelve patients with metastatic cancer pain with a 75 percent success rate.³⁷ The longest duration of pain relief was twelve months.

Our criteria for choosing this method of pain relief are as follows: (1) diffuse distribution of the pain involving more than two or three spinal segments bilaterally; (2) low segmental pain such that it cannot be controlled with celiac plexus blocks and the risk of bladder and bowel control is great resulting from subarachnoid injection of alcohol at such a low level; and (3) patients' fear of the use of neurolytic agents or the discomfort resulting from any procedures.

The theoretical complications involved with this procedure would include paresthesia, loss of bladder and bowel control, spread of cancer cells within the subarachnoid space, and spinal headaches. However, we have seen only two cases of self-limiting headaches and one case of transient bladder dysfunction lasting for two days.

The mechanism for its analgesic effect is still not clear. It may be the result of a demyelination process³⁸ or stimulation of the large nerve fibers in the dorsal column spinal cord effecting gate closure according to the gate closure theory of pain by Melzack and Wall.³⁹ □

REFERENCES

1. Bonica, J.J. Pain: basic principles of management. *Northwest Med.*, 69:567-568, 1970.
2. Murphy, T. Cancer pain. *Postgrad. Med.*, 53:187-194.
3. ———. The management of cancer pain. *GP*, 10:34-43.
4. Paterson, R. *The Treatment of Malignant Disease by Radiotherapy*. Edward Arnold, London.
5. Whiteley, H.W.; Stearns, M.W.; Leaming, R.H., *et al.* Radiation therapy in palliative management of patients with recurrent cancer of rectum and colon. *Surg. Clin. N. Am.*, 49:381-387.
6. Parker, R.G. Pain relief for the cancer patient through selective radiation therapy. *Northwest Med.*, 69:556-568.
7. Nisce, L.Z.; and Chu, F.C. Radiation Therapy of Brachial Plexus Syndrome from Breast Cancer. *Radiology*, 91:1022-1025.
8. Cole, M.P.; Jones, C.T.A.; and Todd, I.D.H. A new anti-oestrogenic agent in late breast cancer: an early clinical appraisal of ICI 46474. *Brit. J. Cancer*, 25:270.
9. Treves, N.; and Finkbeiner, J.A. An evaluation of therapeutic surgical castration in the treatment of metastatic recurrent and primary inoperable mammary carcinoma in women. *Cancer*, 11:421.
10. Pearson, O.H.; Bronson, S.R.; Havrold, C.C.; *et al.*

Hypophysectomy in treatment of advanced cancer *JAMA*, 161:17-21

11. Beaton, G.T. On the treatment of inoperable cases of cancer of the mamma suggestions for a new method of treatment with illustrative cases. *Lancet*, 2:104, 1962
12. Cole, W.J. *Chemotherapy of Cancer*. Lea & Febiger, Philadelphia, 1970.
13. Harrison, D.F. Role of chemotherapy in current concepts in cancer. *JAMA*, 220:405-406, 1972.
14. Sacerdote, P. Theory and practice of pain control in malignancy and other protracted or recurring painful illnesses. *Int. J. Clin. Exp. Hypn.*, 18:160-180, 1970.
15. Mersky, H.; and Hester, R.A. Treatment of chronic pain with psychotropic drugs. *Post-Grad. Med. J.*, 48:594, 1972.
16. Beecher, H.K. The measurement of pain. *Pharmacol. Rev.* 9:59, 1965.
17. Goodman, L.A.; and Gilman, A. *The Pharmacological Basis of Therapeutics*. Third Edition. Macmillan, New York, 1965.
18. Moertel, C.G., *et al.* A comparative evaluation of marketed analgesic drugs. *N. Eng. J. Med.*, 286:813, 1972.
19. Moertel, C.G., *et al.* Relief of pain by oral medications. *JAMA*, 229:55-59, 1974
20. Beaver, W.T. The pharmacologic basis for the choice of an analgesic. (1. Potent Analgesics.) *Pharmacol. Physicians*, 4:1, 1970.
21. White, J.C.; and Sweet, W.H. *Pain and the Neurosurgeon: A Forty-Year Experience*. Charles C. Thomas, Publisher, Springfield, Illinois, pp. 607-609, 1969.
22. Rosomoff, H.L.; Brown, C.J.; and Sheptak, P. Percutaneous radiofrequency cervical cordotomy. *Technique. J. Neurosurg.* 23:639-644, 1965.
23. Tenicela, R.; and Tung, A. *Implantation of Epidural Catheter Electrode for Pain Relief. Work in Progress*.
24. Jacobs, R.G.; and Howland, W.S. A comparison of intrathecal alcohol and phenol. *J. Ky. Med. Assn.*, 64:408, 1966.
25. Khalili, A.A.; and Ditzler, J.W. Neurolytic substances in the relief of pain. *Med. Clin. N. Amer.*, 52:161, 1968.
26. Dogliotti, A.M.; and Ciocatto, E. Method of differential block in pain relief. *Anaesthesiology*, 16:623, 1955.
27. Derrick, W.S. Subarachnoid alcohol block for the control of intractable pain. *Acta Anaesthe. Scand., Suppl.*, 24:167, 1966.
28. Maher, R.M. Relief of pain in incurable cancer. *Lancet*, 1:18, 1955.
29. Nathan, P.W.; Sears, T.A.; and Smith, M.C. Effects of phenol solutions on the nerve roots of the cat: an electrophysiological and histological study. *J. Neurol. Sci.*, 2:7, 1965.
30. Kappis, M. *Erfahrungen Mit Localanesthesia der Bauchoperationen*. Verhandl der Deutsch. Gesellsch. F. Chir. 43:87.
31. Black, A.; and Dwyer, B. Coeliac plexus block. *Anaesthesia and Intensive Care*, 1:315-318, 1974.
32. Bridenbaugh, D.L.; Moore, D.C.; Campbell, D.E. Management of upper abdominal cancer pain: treatment with celiac plexus block with alcohol. *JAMA*, 190:877-880, 1964.
33. Hitchcock, E. Hypothermic subarachnoid irrigation for intractable pain. *Lancet*, 1:1133, 1967.
34. Hitchcock, E.; and Prandini, M.N. Hypertonic saline in management of intractable pain. *Lancet*, 310:312, Feb. 10, 1973.
35. Hitchcock, E. Osmotic neurolysis for intractable facial pain. *Lancet*, 1:434, 1969.
36. Lloyd, J.W.; Hughes, J.T.; and Davies-Jones, G.A.B. Relief of severe intractable pain by barbotage of the CSF. *Lancet*, 1:354, 1972.
37. Tung, A.; Tenicela, R.; and Kao, C.K. Treatment of cancer pain with cerebrospinal fluid barbotage. (Submitted for Publication in *Pain Journal*.)
38. Bunge, R.P.; Bunge, M.B.; Ris, H. Electron microscopic study of demyelination in an experimentally induced lesion in adult cat spinal cord. *J. Biophysic. and Biochem. Cytol.*, Vol. 7, No. 4, Page 685, 1960.
39. Melzack, R.; and Wall, P.D. Pain mechanisms: a new theory. *Science*, 150:971-979, 1965.

Dysuria in women

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Erie



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The urologist is commonly at a severe disadvantage when first confronted with the female patient whose distress is that of frequent, uncomfortable urination, pelvic pressure, burning sensations, and assorted allied complaints. She has quite often been seen and treated by someone else—a family physician, a well meaning relative, or a friend who has “had the same trouble.” She has generally taken sulfonamides, or penicillin, or azo dyes, or other medication the name of which she does not know.

The literature abounds with studies of these genuinely troubled individuals and is replete with careful bacteriological evaluations, checks on vaginal secretions, and therapeutic trials with a wide variety of antimicrobials, antispasmodics, antihistaminics, tranquilizers, and instrumentation.

Dans and Klaus¹ recently reported observations on a group of 106 patients in which 22 had to be excluded because they were taking antimicrobial medication at the first visit. The remainder had careful bacteriological studies, examination of vaginal secretions, and close followup during and after therapy. Unhappily no clear guidelines for management of the individual case have been forthcoming.

Here, as in most such studies, the emphasis has been on bacte-

riological findings. It has been our observation that fully as much attention needs to be paid to the presence or absence of obstructive factors in the patient. It is still axiomatic that the unobstructed urinary tract is quite resistant to infection.

Obstruction in the female urinary tract may be transient or persistent. The classical example of the transient type is what, until relatively recently, was called “honey-moon cystitis.” Here the young bride, who has had no urinary tract problems of any sort, finds herself precipitated into an episode of frequent, urgent, burning urination, often with terminal spotting of blood. This has clearly been pursuant to her first experiences with sexual intercourse. Although the “honeymoon” no longer appears to be an essential feature of the history the symptom complex is still very much with us. Treatment of the acute episode is generally simple, since the “cystitis” responds to a wide variety of antimicrobial medications. The problem becomes one of preventing recurrences.

It may be assumed that in these cases there was not really a transference of pathogenic organisms in the sense of the passing along of a communicable disease, but gonorrhea must be excluded by laboratory studies. The ubiquitous colon

bacillus is the commonest offender. It does not necessarily need to be contributed by a sexual partner.

The precipitating factor here is not the arrival of the colon bacillus on the scene. It is the sudden development of a transient urethral obstruction due to edema and swelling from the trauma of the sexual experience which may include foreplay and orogenital contacts as well as intromission. Given a degree of temporary obstruction, if the bacterium is at hand, everything is set for the acute urethritis or cysto-urethritis to develop.

This, however, is only one kind of obstructive predisposition. Other transient obstructions may follow masturbation, horseback or bicycle riding (even the stationary exercise bicycle), straddle injuries, inept douching, insertion of tampons and the like. It seems certain that allergic problems may beset the mucosal and skin surfaces of the vulvo-vaginal area even as they do the nose and throat. It is not too uncommon to find that soaps, detergents used in washing undergarments, bubble baths, deodorants, condoms, contraceptive creams, diaphragms or other contact agents may be identified as the offenders.

Obviously the long term management of the problem hinges on identification and elimination of the predisposing factor. If elimination is impractical, as in the case of normal sexual intercourse, proper management with protective doses of antimicrobial medications at appropriate times may be quite satisfactory, keeping in mind the general undesirability of repetitious dosings with potent medications.

The persistent or chronic obstructions differ substantially. The child born with a congenitally small urethra or meatal stenosis may have no symptoms of trouble until infection does supervene. The woman whose urethra has been extensively and perhaps repeatedly traumatized in childbirth, or by catheters, indwelling or otherwise, may well date her problems from those episodes. In any event, the work-up should almost certainly include calibration of the urethra with bougies á boule since simple inspection may be misleading.

It is not the purpose of this commentary to attempt to resolve the differences between those who dilate tight urethras, those who do internal urethrotomies, or those who do other plastic procedures on the urethra. It does appear, however, that treatment directed at overcoming the obstruction is indeed the secret of success.

The choice of antimicrobial agents is wide. As Dans and Klaus have observed, "Drug choice will depend upon specific characteristics: efficacy, cost, allergenicity, toxicity, convenience." Usually sulfonamides or ampicillin will do the job at minimum expense and risk.

It has impressed me as important, in the acute case, to avoid instrumentation, save possibly for catheterization if this is necessary to obtain a suitable specimen for urine culture. Antimicrobial therapy is started and continued at full dosage for one week after the cessation of acute symptoms. A recheck examination is carried out at this time—usually about 10 days after initiation of therapy. At that time urethral calibration may be done without acute discomfort to the patient. If all is well, drugs are decreased to a maintenance level. One may switch from sulfonamides or ampicillin to nitrofurantoin, mandelic acid preparations, or nalidixic acid if there is concern for longer range toxicity. This is continued at a minimal prophylactic level for a month, when recalibration and recheck are carried out, and the decision is made as to the need for further study or additional procedures.

Routine endoscopy and excretory urography are probably "unnecessary" as part of the work-up in these cases in the absence of special indications or therapeutic failures. In the case of a persistence of pyuria, hematuria, or disturbing symptoms it is important first to secure excretory urograms, and then to proceed with endoscopy. If there are urographic abnormalities of the kidneys (failure to visualize, hydronephrosis, evidence of pyelonephritis, calculus, etc.) upper tract studies, as appropriate, may be carried out at the time of initial endoscopic study. Special attention should be paid to the urethra for evidence of diverticulum or paraurethral infections.

In any event it is my conviction that primary attention must be paid to abnormalities, transient or persistent, in the host. The invading organism is a secondary, albeit important, factor. Attention to the organism alone is likely to yield unsatisfactory results in long-range management.

There will inevitably be some patients for whom no predisposing factor can be identified, who show no evidence of urinary tract infection. If there is also no vaginitis or cervicitis one needs to consider allergy. Therapeutic trial may be given first with pyridium and/or urinary tract antispasmodics, and later, if necessary, with antihistaminics and/or corticosteroids for a short course.

The occasional patient will still have her complaints. Endoscopy and excretory urography are then in order. Bladder capacity should be determined. Careful search for evidences of interstitial cystitis should be carried out.

When nothing is found to explain the persisting complaint one should consider psychiatric evaluation rather than beginning endless experimentation with tranquilizers, *et al.*

Conclusion

End stage renal disease is a major problem. Our federal government, through extensions of medicare coverage, has undertaken financial responsibility for much of the cost of managing ESRD. This currently runs at the half-billion dollar mark and is expected to exceed one billion within a very few years.

There is a new enthusiasm on the part of urologists for prevention instead of management of destroyed kidneys. Clearly, one well-defined avenue of approach is the recognition and control of ascending urinary tract infections which lead to chronic pyelonephritis, and all of its complications. This may only be accomplished by diligent and conscientious handling of the early stage infections, many of which have been considered above. □

REFERENCE

1. Dans, P.E.; and Klaus, B. Dysuria in women. *Johns Hopkins Med. J.*, 138: 13-17, 1976.



Chest burns in the young girl

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Chest burns in young children as the result of contact with hot liquids are common. These are infrequently lethal and usually of partial thickness. Flame burns secondary to burning clothing and liquid contact burns that develop secondary infection will become full thickness in depth.

In young girls, full thickness burns of the breast area will alter future breast development. Complete loss of the nipple-areolar complex and subcutaneous glandular tissue results in amastia. Lesser degrees of nipple-areolar loss will produce a small distorted breast, absence of the nipple, and failure of lactation.

The potential consequences of chest wall burns in immature females must be borne in mind by the physician. Initial treatment is extremely important especially when the only area burned is the anterior chest as so often happens with a scald burn resulting from the child's pulling a pot of coffee or tea over onto herself. The injured area should be cooled immediately following the injury and for

4-24 hours afterwards. Topical treatment should then include either biological dressings or topical antibiotics. Initially the child should receive antibiotic therapy against streptococcus and staphylococcus. Either cutaneous allografts or amniotic membrane may be used as biological dressing. Both of these are preferable to porcine xenografts.

A very deep partial thickness injury may require early tangential excision and over grafting with thin split grafts. Their placement is usually delayed for 8-24 hours to diminish the risk of hematoma and graft necrosis. Grafts are secured with adhesive paper strips and a single layer of xeroform® gauze followed by wet mechanic's waste held in place with an overwrap of self adherent gauze and an elastic bandage.

The parents should be informed about the potential problems with breast development in any of these injuries. Whenever chest wall eschar excision of full thickness skin is required a potentially inconspicuous donor site should be selected (e.g., buttock).

For the young woman who has a breast deformity secondary to a childhood burn, reconstructive surgery may be feasible and desirable. If only the nipple-areolar area is

absent a labia minora free graft or split graft from the opposite nipple can be done over a deepithelialized area on the breast mound. Following pregnancies lactation should be suppressed.

If breast development is lacking, an augmentation mammoplasty utilizing a silicone prosthesis can be done. When necessary nipple-areolar reconstruction as previously described can be done simultaneously with augmentation. Occasionally breast and nipple development are adequate but the mound is distorted by the contracted burn scar. In such instances a thick split skin graft from the buttock or a full thickness skin graft from the groin can be used to release the contracture. Whenever skin grafts are taken, they should be removed in such a way that the donor site will not be conspicuous despite whatever scarring may result.

It is apparent that the full impact of a burn of the chest in a young girl cannot be predicted until sexual maturity has occurred. Whenever the breast anlage has been damaged varying degrees of maldevelopment may occur. The parents of the child must be made aware of the long term implications of these injuries. □



Figure 1. Teenage girl burned at age 3 with hot water has failed to develop a nipple.

This paper was prepared by the department of surgery, division of plastic surgery, The Milton S. Hershey Medical Center, The Pennsylvania State University, Hershey. The Pennsylvania Division of the American Trauma Society and the State Society's Commission on Emergency Medical Services assist in the dissemination of information on trauma.



Figure 2. Middle aged white female whose chest burn occurred 35 years ago exhibits marked mammary asymmetry.

Case report

Villous tumor of the stomach

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Villous tumors of the gastrointestinal tract represent a well defined disease entity. Although common in the sigmoid colon and rectum, the villous tumor is rare in the upper gastrointestinal tract. This is a report of a villous tumor of the stomach and the interesting constellation of symptoms associated with the tumor.

Report of a case

A 67 year old white female was admitted to the Milton S. Hershey Medical Center because of abdominal pain.

She was well until nine months earlier when she began to experience nonradiating, mid-epigastric, sharp pain associated with nausea and belching. The pain was unrelated to posture and occurred 10 to 15 minutes after the ingestion of food, gradually subsiding after one-half hour. She had been evaluated at another institution five months before admission to Hershey; an upper gastrointestinal series had demonstrated a gastric mass. A gastroscopy was said to be normal two months later although the pylorus was not visualized.

During the 8 weeks preceeding admission her symptoms increased in frequency and the patient experienced fatigue, early satiety, anorexia and a 10 kg weight loss. There was no history of vomiting, hematemesis,

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melena, change in bowel habits, fever, chills, or sweats.

The vital signs were normal. The patient was obese and in no acute distress. The remainder of the physical examination was normal except for the abdomen which revealed a generalized tenderness to palpation. Bowel sounds were normal and there was no evidence of mass or organomegaly.

Except for an hematocrit of 31 percent, routine laboratory studies were normal. The serum sodium was 142

mEq/l and the potassium was 2.6 mEq/l. The serum iron was 28 μ g percent and the total iron binding capacity was 423 μ g percent.

A chest x-ray, sigmoidoscopy, and barium enema were normal. An upper gastrointestinal x-ray showed a polypoid mass lesion in the pylorus which prolapsed into the first portion of the duodenum (Figure 1). Endoscopic examination revealed a large, sessile, lobulated tumor in the distal portion of the stomach 1 cm proximal to the pylorus.

At laparotomy the tumor was noted to arise from a short, broad pedicle in the pre-pyloric area of the gastric antrum and had the appearance of a villous adenoma. The mass was excised



Figure 1. Upper gastrointestinal spot film demonstrates the polypoid mass lesion of the stomach which is prolapsing into the duodenum.



Figure 2. Photomicrograph demonstrating a cross section of the villous tumor.

and after the diagnosis of villous tumor was made on frozen section, a partial antrectomy and gastrojejunostomy was performed. The post-operative period was uncomplicated and the patient was asymptomatic one year later.

Pathology

Gross examination of the resected portion of the stomach revealed a single, pink, soft polypoid tumor measuring 3 x 2.5 x 2 cm arising from a broad stalk measuring 2 x 1.5 cm (Figure 2). Focal areas of hemorrhage were noted on the surface of the polyp. The tumor arose from the posterior wall of the antrum just proximal to the pylorus. Microscopically it was composed of villous and adenomatous structures (Figure 3). The cells presented a uniform appearance with basal nuclei and large amounts of apical mucinous material. Some mitotic figures were noted, but there was no evidence of cellular atypicity. The edematous stroma contained loose connective tissue, small bundles of smooth muscle and acute and chronic inflammatory cells. The surface was marked by focal areas of mucosal erosion and hemorrhage with an infiltrate of polymorphonuclear leukocytes.

Discussion

Villous tumors of the gastrointestinal tract are rare.¹⁻⁴ Bremer, et al⁵, collected 72 cases by 1968. There

were a total of 92 tumors of the upper gastrointestinal tract, 82 of which were located in the stomach.

The clinical features of this lesion are interesting. Patients frequently present with tiredness and other symptoms related to anemia. In a review of the literature by Walk,⁶ 75 percent of the patients had stools which were positive for occult blood. These tumors have a large surface area which is friable and bleeds chroni-



Figure 3. Photomicrograph of villous tumor demonstrating villous and adenomatous structures.

cally, leading to anemia, as seen in this patient.

Symptoms of gastric outlet obstruction are rare. Our patient demonstrated post prandial, epigastric pain, weight loss, nausea, and early satiety. We feel that the location of the tumor, in the distal portion of the stomach with prolapse into the first part of the duodenum, was responsible for these obstructive symptoms.

Hypokalemia has not been reported in villous tumors of the upper gastrointestinal tract.⁵ It is possible that, like their histologic counterparts in the colon, they secrete large quantities of fluid and electrolytes; however, reabsorption of fluid and electrolytes could occur during passage through the intestinal tract. Our patient had a potassium of 2.6 mEq/l; however, she had been taking hydrochlorothiazide in a dosage of 50 mg daily. Because of this, we cannot attribute hypokalemia to the villous tumor; however, all potassium values were normal post-operatively.

The radiologic findings have been well described.⁷ The upper gastrointestinal series demonstrates a typical "soap bubble" effect. This appearance is produced by deposition of barium between the fronds of the tumor and aids in pre-operative diagnosis.

Gastric villous tumors have a potential for malignancy. The incidence of malignancy is estimated by Bremer, et al, to be greater than 50 percent. Because of this high incidence we feel that all villous tumors of the upper gastrointestinal tract should be excised surgically. □

REFERENCES

1. Bockus, H.L. Gastroenterology. Philadelphia and London 1964, W. B. Saunders Co., Vol. II, 2nd Edit. p. 180.
2. Rhiford, T.S. Tumors of the small intestine. Arch. Surg., 25: 122 & 321, 1932.
3. Darling, C.R.; and Welch, C.E. Tumors of the small intestine. N. Eng. J. Med., 260:397, 1959.
4. River, L.; Silverstein, J.; and Tope, J.W. Benign neoplasm of the small intestine: a critical, comprehensive review with reports of 20 new cases. Int. Abstr. Surg., 102:1, 1956.
5. Bremer, E.H.; Battaile, W.G.; and Bulle, P.H. Villous tumors of the upper gastrointestinal tract. Am. J. Gastroenterology, 50:135, 1968.
6. Walk, L. Villous tumor of the stomach: clinical review and report of 2 cases. Arch. Int. Med., 87:560, 1952.
7. Saibil, E.; Guttman, F.; and Palayew, M.J. Villous adenoma of the duodenum: a case report and review of the literature. J. Canad. Assoc. Rad., 23:257, 1972.

In vitro susceptibility updated and still virtually unchanged

Schering

A five-year history of pathogen susceptibility to Garamycin® (gentamicin sulfate) — 1971-1975

	1971	1972	1973	1974	1975
Gram-Negative Susceptibility No. of Patient Isolates	98% 89,317	97% 113,473	97% 127,763	97% 150,094	97% 193,626
 <i>Escherichia coli</i>	99%	99%	99%	99%	99%
 <i>Proteus species,</i> indole-negative	98%	99%	99%	99%	99%
 <i>Proteus species,</i> indole-positive	97%	96%	94%	94%	92%
 <i>Pseudomonas</i> <i>aeruginosa</i>	96%	96%	95%	94%	95%
 <i>Klebsiella-</i> <i>Enterobacter-</i> <i>Serratia</i>	99%	98%	99%	99%	98%
Staphylococcal Susceptibility No. of Patient Isolates	97% 6,995	98% 11,109	98% 12,225	99% 18,352	99% 28,130
 <i>Staphylococcus</i> <i>aureus</i>	97%	98%	98%	99%	99%
 <i>Staphylococcus</i> <i>epidermidis</i>	97%	97%	98%	98%	98%

Source: PMR Bacteriologic Reports — 1971-1975

These *in vitro* data are based on results obtained from a nationwide panel of 180 acute-care hospitals of 100 beds or more. All hospitals in the audit used the Kirby-Bauer method of disc sensitivity. Data are presented in unweighted form.

In vitro susceptibility data are not necessarily indicative of clinical effectiveness.

See Clinical Considerations section which follows...

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WARNING

Patients treated with GARAMYCIN Injectable should be under close clinical observation because of the potential toxicity associated with the use of this drug.

Ototoxicity, both vestibular and auditory, can occur in patients, primarily those with pre-existing renal damage, treated with GARAMYCIN Injectable usually for longer periods or with higher doses than recommended.

GARAMYCIN Injectable is potentially nephrotoxic, and this should be kept in mind when it is used in patients with pre-existing renal impairment.

Monitoring of renal and eighth nerve function is recommended during therapy of patients with known impairment of renal function. This testing is also recommended in patients with normal renal function at onset of therapy who develop evidence of nitrogen retention (increasing BUN, NPN, creatinine or oliguria). Evidence of ototoxicity requires dosage adjustments or discontinuance of the drug.

In event of overdose or toxic reactions, peritoneal dialysis or hemodialysis will aid in removal of gentamicin from the blood.

Serum concentrations should be monitored when feasible and prolonged concentrations above 12 mcg./ml. should be avoided.

Concurrent use of other neurotoxic and/or nephrotoxic drugs, particularly streptomycin, neomycin, kanamycin, cephaloridine, viomycin, polymyxin B, and polymyxin E (colistin), should be avoided.

The concurrent use of gentamicin with potent diuretics should be avoided, since certain diuretics by themselves may cause ototoxicity. In addition, when administered intravenously, diuretics may cause a rise in gentamicin serum level and potentiate neurotoxicity.

USAGE IN PREGNANCY Safety for use in pregnancy has not been established.

INDICATIONS GARAMYCIN Injectable is indicated, with due regard for relative toxicity of antibiotics, in the treatment of serious infections caused by susceptible strains of the following microorganisms:

Pseudomonas aeruginosa, *Proteus* species (indole-positive and indole-negative), *Escherichia coli* and *Klebsiella Enterobacter-Serratia* species

Clinical studies have shown GARAMYCIN Injectable to be effective in septicemia and serious infections of the central nervous system (meningitis), urinary tract, respiratory tract, gastrointestinal tract, skin and soft tissue (including burns).

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In suspected or documented gram-negative sepsis, GARAMYCIN may be considered as initial therapy. The decision to continue therapy with this drug should be based on the results of susceptibility tests, the severity of the infection, and the important additional concepts contained in the Warning Box.

For suspected sepsis when the infecting organism is unknown, gentamicin may be administered in conjunction with a penicillin-type drug. Following identification of the organism and its susceptibility, appropriate antibiotic therapy should then be continued. In the neonate with suspected sepsis or staphylococcal pneumonia, a penicillin type drug is also usually indicated as concomitant therapy with gentamicin.

GARAMYCIN Injectable has been shown to be effective in serious staphylococcal infections. It may be considered in those infections when penicillins or other less potentially toxic drugs are contraindicated and bacterial susceptibility testing and clinical judgment indicate its use.

CONTRAINDICATIONS A history of hypersensitivity to gentamicin is a contraindication to its use.

WARNINGS See Warning Box.

PRECAUTIONS Neuromuscular blockade and respiratory paralysis have been reported in the cat receiving high doses (40 mg./kg.) of gentamicin. The possibility of these phenomena occurring in man should be considered if gentamicin is administered to patients receiving neuromuscular blocking agents, such as succinylcholine and tubocurarine.

Treatment with gentamicin may result in overgrowth of nonsusceptible organisms. If this occurs, appropriate therapy is indicated.

ADVERSE REACTIONS:

Nephrotoxicity: Adverse renal effects, as demonstrated by rising BUN, NPN, serum creatinine and oliguria, have been reported. They occur more frequently in patients with a history of renal impairment treated with larger than recommended dosage.

Neurotoxicity: Adverse effects on both vestibular and auditory branches of the eighth nerve have been reported in patients on high dosage and/or prolonged therapy. Symptoms include dizziness, vertigo, tinnitus, roaring in the ears and hearing loss.

Numbness, skin tingling, muscle twitching, and convulsions have also been reported.

Note: The risk of toxic reactions is low in patients with normal renal function who do not receive GARAMYCIN Injectable at higher doses or for longer periods of time than recommended.

Other reported adverse reactions, possibly related to gentamicin, include increased serum transaminase (SGOT, SGPT), increased serum bilirubin, transient hepatomegaly, decreased serum calcium, splenomegaly, anemia, increased and decreased reticulocyte counts, granulocytopenia, agranulocytosis, thrombocytopenia, purpura; fever, rash, itching, urticaria, generalized burning, joint pain, laryngeal edema; nausea, vomiting, headache, increased salivation, lethargy and decreased appetite, weight loss, pulmonary fibrosis, hypotension and hypertension.

DOSAGE AND ADMINISTRATION

GARAMYCIN Injectable may be given intramuscularly or intravenously.

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Adults: The recommended dosage for GARAMYCIN Injectable for patients with serious infections and normal renal function is 3 mg./kg./day administered in three equal doses every 8 hours.

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In patients with life-threatening infections, dosages up to 5 mg./kg./day may be administered in three or four equal doses. This dosage should be reduced to 3 mg./kg./day as soon as clinically indicated.

In children and infants, the newborn, and patients with impaired renal function, dosage must be adjusted in accordance with instructions set forth in the Package Insert.

For Intravenous Administration:

The intravenous administration of GARAMYCIN Injectable is recommended in those circumstances when the intramuscular route is not feasible (e.g., patients in shock, with hematologic disorders, with severe burns, or with reduced muscle mass).

For intravenous administration in adults, a single dose of GARAMYCIN Injectable may be diluted in 10 or 200 ml. of sterile normal saline or in a sterile solution of dextrose 5% in water, in infants and children, the volume of diluent should be less. The concentration of gentamicin in solution in both instances should normally not exceed 1 mg./ml. (0.1%). The solution is infused over a period of one to two hours.

The recommended dose for intravenous administration is identical to that recommended for intramuscular use.

GARAMYCIN Injectable should not be physically premixed with other drugs, but should be administered separately in accordance with the recommended route of administration and dosage schedule.

HOW SUPPLIED GARAMYCIN Injectable, 40 mg. per ml., is supplied in 2 ml. (80 mg.) multiple-dose vials and in 1.5 ml. (60 mg.) and 2 ml. (80 mg.) disposable syringes for parenteral administration.

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(Continued on next page)

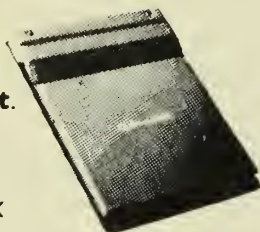
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obituaries

• Indicates membership in the Pennsylvania Society at time of death.

• **John T. Delehanty**, Hazleton; Jefferson Medical College, 1939; age 66; died September 17, 1976. He was a past president of the Luzerne County Medical Society, Hazleton Branch. Information regarding survivors is unavailable at this writing.

• **John F. Hartman, Jr.**, Erie; Temple University School of Medicine, 1933; age 69; died October 17, 1976. He had served as chairman of the State Society's Council on Public Service (now the Council on Professional Relations and Services) and of the Committee to Nominate Delegates and Alternates to the AMA, a member of the Committee on Objectives and the Medical Care Coordinating Committee, and a district censor. His wife, two daughters, and a son survive him.

• **Norman A. Karmilowicz**, Kingston; University of Rochester School of Medicine and Dentistry, 1932; age 71; died October 14, 1976. He had practiced medicine in Kingston since 1932. His wife, a son, Norman P. Karmilowicz, M.D., a sister, and a brother survive him.

• **David P. McCune**, Elizabeth; University of Pittsburgh School of Medicine, 1907; age 92; died October 10, 1976. He had been chief of urology at McKeesport Hospital 1920 to 1950, and on the consulting staff 1950 to 1964. He had served as president of the Northeastern Section of the American Urological Association 1940 to 1941. A son, William W. McCune, M.D., and a sister survive him.

• **Ronald V. Silknetter**, Altoona; University of Pittsburgh School of Medicine, 1925; age 75; died September 4, 1976. He is survived by his wife and a daughter.

• **Clyde E. Tibbens**, Washington; Jefferson Medical College, 1916; age 88; died September 30, 1976. He had practiced medicine in Washington for 35 years. His wife, a daughter, and a son, George F. Tibbens, M.D., survive him.

• **David E. Vogan**, Mercer; University of Pittsburgh School of Medicine, 1912; age 87; died October 9, 1976. Information regarding survivors is unavailable at this writing.

• **Woodrow W. Wendling**, Camp Hill; Temple University School of Medicine, 1943; age 59; died October 8, 1976. He was chief of Employee Health Services for the State. His wife, his mother, three sons, and a brother survive him.

• **Lucy M. Wunderly (Hill)**, Allentown; Woman's Medical College, 1931; age 72; died September 13, 1976. A child psychiatrist, she was in private practice in Pittston until joining the children's division of the Philadelphia Department of Health in 1951. From 1958 to 1968 she worked in

the children's unit of the Allentown State Hospital and received the hospital's first Shettel Award for meritorious service in 1968. Until 1974 she was associated with the Lehigh Valley Child Guidance Clinic. Two sons, one of whom is Charles H. Hill, M.D., five brothers, and six sisters survive her.

• **Edward F. Burt**, Cape May Court House, New Jersey; University of Pennsylvania School of Medicine, 1925; age 76; died October 18, 1976. He was an associate professor of pediatrics at Jefferson Medical College 1926 to 1976. He is survived by his wife, a daughter, a son, and a sister.

• **J. Donald Conn, Sr.**, Mesa, Arizona; University of Pennsylvania School of Medicine, 1937; age 65; died October 4, 1976. Three daughters and a son survive him.

• **Henry R. Douglas, Jr.**, Grantham; University of Pennsylvania School of Medicine; age 73; died October 1, 1976. Four sisters survive him.

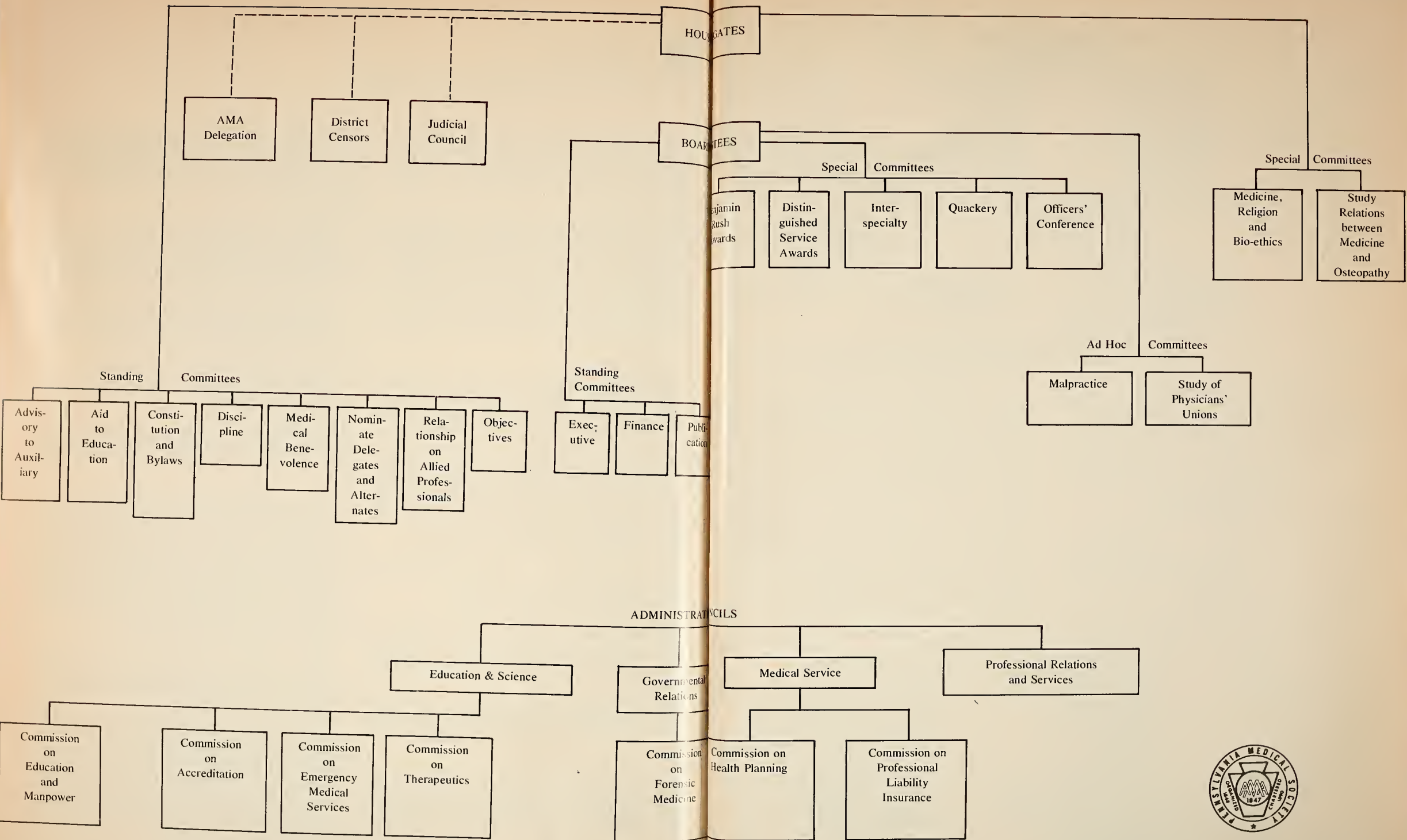
• **Halburt H. Earp**, North Readington Beach, Florida; Jefferson Medical College, 1928; age 74; died September 25, 1976. His wife and a son, William L. Earp, M.D., survive him.

• **James I. Forsyth**, Mt. Holly Springs; Hahnemann Medical College and Hospital; age 46; died September 27, 1976. In addition to his work as an emergency physician, he practiced law and was an assistant adjunct professor of law at Dickinson Law School. He was a special assistant to the deputy attorney general of the State. A member of the College of Utilization Review, he was chairman of the utilization review board at the Cumberland County Nursing Home. His wife, his mother, two daughters, and a brother, G. A. Forsyth, M.D., survive him.

• **Robert W. Haines**, West Hartford, Connecticut; Jefferson Medical College; age 55; died September 10, 1976. His wife, a daughter, two sons, and two brothers survive him.

• **Robert C. Horn**, Grosse Point, Michigan; Yale University School of Medicine, 1937; age 63; died October 4, 1976. He had been selected as 1976 Pathologist of the Year by the College of American Pathologists and the American Society of Clinical Pathologists. He was a past president of the College of American Pathologists and the Michigan Society of Pathologists. His wife, two sons, Robert C. Horn, III, M.D., and Thomas L. Horn, M.D., a daughter, two sisters, and a brother survive him.

• **James P. McCormick, M.D.**, Norristown; Johns Hopkins University School of Medicine; age 50; died September 27, 1976. His mother, three brothers, and four sisters survive him.



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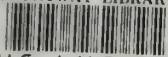
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